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<div style="display: flex; justify-content: space-between;"> <span>07707</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>07697</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  <b>CERTIFICATE OF DEATH</b> </div>												
1. DECEASED NAME (Type or print)			First <b>KRISTA</b>		Middle <b>D.</b>		Last <b>ALLEN</b>		2a. DATE OF DEATH Month <b>JUNE</b> Day <b>9</b> Year <b>1969</b>		2b. HOUR <b>4:20</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>7-14-1968</b>			6. AGE (in years last birthday) <b>YRS. 10</b>		IF UNDER 1 YEAR MONTHS <b>10</b> DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>						
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address of place) <b>MEMORIAL HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired.) <b>NONE</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>W. VA.</b>		13b. COUNTY <b>MINERAL</b>		13c. CITY OR TOWN <b>KEYSER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RT. 4</b>				
14. FATHER'S NAME First <b>PAUL</b> Middle <b>ALLEN</b> Last			15. MOTHER'S MAIDEN NAME First <b>JUDITH</b> Middle <b>TASKER</b> Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b> Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PURULENT MENINGITIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>6/6</b> , 19 <b>67</b> , to <b>6/7</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>6/9</b> , 19 <b>67</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Robert J. Dawson</b>		22c. DATE SIGNED <b>6/11/69</b>		22d. ADDRESS <b>500 GREENE ST., CUMBERLAND, MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12 June 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Tasker</b>		23d. LOCATION (City or Town) (County) (State) <b>Cross Mineral W. Va.</b>						
24. FUNERAL DIRECTOR <b>Allen M. Rotnick</b>		25a. REC'D BY REGISTRAR <b>June 16 1969</b>		25b. REGISTRAR'S SIGNATURE <b>William A. Judge</b>								

TESTO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 113 (4)  
45M - 1-69

07708

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07699

1. DECEASED-NAME (Type or print)			First MINNIE	Middle NMI	Last ARNOLD	2a. DATE OF DEATH Month 06 Day 17 Year 69			2b. HOUR 11:35M					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 10-23-89		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY COUNTY, Md.								
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife,		12b. KIND OF BUSINESS OR INDUSTRY own home								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Bowling Green 41 CRESAP DRIVE						
14. FATHER'S NAME First JAMES			Middle EDWARDS			Last (JONES) ELIZABETH			15. MOTHER'S MAIDEN NAME First EDWARDS			Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 217-10-4674			17. INFORMANT Address SACRED HEART, SETON DR., CUMB., MD. 21502								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized arteriosclerosis</u> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State				
22a. I certify that (I) (this hospital) attended the deceased from 6-13-69, to 6-17-69, that (I) (we) lost saw the deceased alive on 6-17-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE H. Brings				DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 6-18-69						
22d. PHYSICIAN'S NAME (Type) L. BRINGS, M.D.				22e. ADDRESS 57 GREENE ST., CUMB., MD. 21502										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/20/69		23c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		23d. LOCATION (City or Town) Eckhart, Allegany		(County) Maryland		(State)				
24. FUNERAL DIRECTOR H. Wayne George				ADDRESS MD. 21502		25a. REC'D BY REGISTRAR DATE JUN 23 1969		25b. REGISTRAR'S SIGNATURE Charles J. Smith						

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(M)

10-10-1954 10-10-1954 10-10-1954

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ALLGARY COUNTY, ILL. ILL. ILL.

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ALLGARY COUNTY, ILL. ALLGARY COUNTY, ILL.

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ALLGARY COUNTY, ILL. ALLGARY COUNTY, ILL.

27 GREEN ST., CHRY., ILL. 21503

27 GREEN ST., CHRY., ILL. 21503

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1/69

07709		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07700	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
HARRY R. ASH					06 Month 30 Day 69 Year 10:30A M		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. YRS.
MALE	WHITE		11-5-96		73		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MARYLAND		UNITED STATES				ALLEGANY COUNTY Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND, MD.		MEMORIAL HOSPITAL		RETIRED-KELLY ST. CO.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD.		ALLEGANY CO.		FLINTSTONE		13e. STREET AND NUMBER	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		First		Middle	
JACKSON		ASH		JENNIE		DIEHL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
No		211-05-9954		MEMORIAL HOSPITAL CUMB. MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cerebral Thrombosis							
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular Disease							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 7/30/69, 19, to 7/30/69, 19, that (I) (we) saw the deceased alive on 7/30/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
DR. R. J. WILLIAMS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		7/3/69		Everett Pa Cemetery		Everett Bedford Penna	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Silcox-Merritt Funeral Service, Cumberland, Md		21502		JUL 7 1969		Charles Judge	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07710

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07701

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
Marshall Warren Barthalow						June 28, 1969			1:30a			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	White	12/ 7/1907	61 YRS.					June 28, 1969			1:30a M			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Penna.			USA						Allegany					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Frostburg			Miner's Hospital--DOA			Dept 43			Kelly Springfield					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
Md.			Allegany			Flintstone			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Route 1		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
Clay			Barthalow			Mazie			Ruby					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			216-22-5685			Ruth Fisher Barthalow			Route 1, Flintstone Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Maceration of Brain												2 Hours		
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Skull Fracture												H		
DUE TO, OR AS A CONSEQUENCE OF (c) (Auto Accident)												H		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
About 11:30 PM				6-27-69				Passenger in Auto Accident						
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Rt. # 40				1.3 miles east from top Martin Mt. Allegany, Maryland						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED						
BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				June 28, 1969						
EXAMINER'S NAME (Type)				ADDRESS (Street, city, town, or county)				Cumberland, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY						
Burial				7/1/69				Chaneysville Meth. Cem.						
24. FUNERAL DIRECTOR				23d. LOCATION (City or Town) (County) (State)				25a. REC'D BY REGISTRAR						
Charles E. Hafer				Chaneysville, Bedford, Penna.				JUL 2 1969						
Charles E. Hafer, 230 Balto Ave. Cumberland Md				25b. REGISTRAR'S SIGNATURE				Charles Judge						

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10710

June 28, 1963

June 28, 1963

100-10100-100

Location of train

Boiler pressure

(Auto accident)

Point 11:30 PM 6-27-63

1.5 miles west from top of hill

June 28, 1963

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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07711

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

07702

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
MARGARET				BEAL	JUNE Month 1, Day 1969 Year		7 40 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE		WHITE		JANUARY 10, 1894		75 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		MD.	
MARYLAND		U.S.A.				ALLEGANY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
FROSTBURG		MINERS HOSPITAL		HOUSE WIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		FROSTBURG				KEMP DRIVE	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
DAVID				JONES	ALICE				LEWIS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
				JACK BEAL,		ECKHART, MD. 21528			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensation CVD</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>69</u> , to <u>June 1</u> , 19 <u>69</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>June 1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>by</del> ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)				
<u>John B. Davis</u>		<u>6/2/69</u>			JOHN B. DAVIS, M. D.				
		DEGREE			22e. ADDRESS				
					2 BROADWAY, FROSTBURG, MD. 21532				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		JUNE 3 '69		F.B.G. MEMORIAL PARK		FROSTBURG, MD.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
JOSEPH R. DURST, FROSTBURG, MD. 21532						JUN 4 1969		<u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07712

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07703

1. DECEASED NAME (Type or print) First Middle Last May Anna Beall		2a. DATE OF DEATH June 11 Day 69 Year		2b. HOUR 127P <sup>M</sup>
3. SEX Female	4. RACE White	5. DATE OF BIRTH 7-20-82		6. AGE (In years last birthday) 86 YRS.
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Allegany		Md.		
10. CITY OR TOWN OF DEATH Cumberland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland Nursing Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Funters Cleaners Foreman Dry Cleaners
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER 604 Maryland Ave.				
14. FATHER'S NAME First Middle Last Martin Rizer		15. MOTHER'S MAIDEN NAME First Middle Last Amelia Willison		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 217-10-4463		17. INFORMANT Thomas Beall Husband 604 Maryland Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation recurrent</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio Vasc. Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Exhaustion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <u>12:30 PM</u> to <u>5:00 PM</u> , that (I) (we) last saw the deceased alive on <u>12/11/69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>David T. Rees</u> M.D.		22c. DATE SIGNED <u>12 June 69</u>		
22d. PHYSICIAN'S NAME (Type) <u>DAVID T. Rees M.D.</u>		22e. ADDRESS <u>Box Montgomery Ave</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>6/14/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>
23d. LOCATION (City or Town) (County) (State) <u>Cumberland Allegany Md.</u>				
24. FUNERAL DIRECTOR <u>William G. Kight</u>		25a. REC'D BY REG. STRA. <u>JUN 19 1969</u>		25b. REC'D BY SANITARY <u>REC'D</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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5719

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
CLARENCE FRANCIS BEEM						Month 6 Day 17 Year 69			10:00 AM
3 SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE	WHITE		4-27-18			51 YRS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH
ILLINOIS			USA						ALLEGANY Md
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND			SACRED HEART HOSPITAL			CLAIM DEPT.			B & O RR CO.
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY, MD? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER
MARYLAND			ALLEGANY CUMBERLAND			X			330 RESERVOIR AVE.
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
FRANCIS BEEM			(MARY) Margaret Sexton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
X UNKNOWN War II			344-16-707			HOSPITAL CHART			900 SETON DRIVE CUMBERLAND, MD. 21502
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive Gastrointestinal bleeding</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last									12 hr
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatic Failure</u>									1 wk
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hepatic Cirrhosis</u>									1 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-13, 1969</u> , to <u>6-17, 1969</u> , that (I) (we) lost saw the deceased drive on <u>6-17, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L. Michael Glick</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>6-17-69</u>	
22d. PHYSICIAN'S NAME (Type) <u>L. MICHAEL GLICK, M.D.</u>						22e. ADDRESS <u>912 SETON DRIVE CUMB., MD. 21502</u>			
23a. BURIAL CREMATION <u>BURIAL</u> (Specify)			23b. DATE <u>June 20, 1969</u>			23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Md. Allegany</u>
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REG STRAR		25b. REGISTRAR'S SIGNATURE	
			SCARPELLI FUNERAL HOME 108 VA. AVE., CUMBERLAND, MD.			JUN 24 1969		<u>Charles Glick</u>	

The first part of the report  
 deals with the general situation  
 of the country and the  
 progress of the work.  
 The second part contains  
 a detailed account of the  
 results of the investigations  
 and the conclusions drawn  
 from them.



The third part of the report  
 deals with the financial  
 aspects of the work and  
 the results of the  
 investigations.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
07714											
07705											
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR		
MICHAEL			BEEMANBEERMAN			6 Month 13 Day 69 Year			8:20 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
MALE		WHITE		Feb. 16, 1904		65 YRS					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Penna		U.S.A.				ALLEGANY Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			SACRED HEART HOSPITAL								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND			ALLEGANY			CUMBERLAND			815 BRADDOCK RD.		
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
Israel			Beerman			Rachel			Levinson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 IN SACRED HEART HOSP. EMERGENCY RM. RECORDS			Address 900 SETON DR. CUMBERLAND, MD.		
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))											
PART 1 DEATH WAS CAUSED BY.											
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION											
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
DIABETES MELLITUS											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1963, to 13 JUNE 1969, that (I) (we) last saw the deceased alive on 7 JUNE 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE			MD DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED 6-13-69		
22d. PHYSICIAN'S NAME (Type)			L. M. GLICK, MD.			22e. ADDRESS 912 SETON DR., CUMBERLAND, MD.					
23a BURIAL, CREMATION, OR DISPOSAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			6/15/69			East View Cem.			Cumberland Allegany MD		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
STEIN'S FUNERAL HOME			117 FREDERICK CUMBERLAND, MD			JUN 17 1969			Charles Judge		

Figure 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07715

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07706

1. DECEASED-NAME (Type or print) <b>Margaret</b>			First <b>E.</b>			Middle <b>Bell</b>			Last			2a. DATE OF DEATH Month <b>6</b> Day <b>20</b> Year <b>1969</b>			2b. HOUR <b>3-30</b>		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>10/26/1900</b>			6. AGE (In years last birthday) <b>68</b> YRS			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>			IF UNDER 24 HRS HOURS <b></b> MIN <b></b>		
7a. BIRTHPLACE (State or foreign country) <b>Wva.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Allegany</b> Md.								
10. CITY OR TOWN OF DEATH <b>Frostburg</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Miners Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>NONE</b>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>Allegany</b>			13c. CITY OR TOWN <b>Lonaconing</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>High Street</b>					
14. FATHER'S NAME First <b>Joseph</b> Middle <b>Elkins</b>						15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Gay</b> Last <b></b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Glenn Bell</b>			Address <b>Lonaconing, Md.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> 4 1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Atherosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs.</b> <b>10 days</b> <b>years</b>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus</b>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>June 20, 1969</b> , to <b>June 20, 1969</b> , that (I) (we) last saw the deceased alive on <b>June 20, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (us) (did not) view the body after death																	
22b. SIGNATURE <b>L.R. Miles, Jr.</b>			22c. DATE SIGNED <b>6.21.69</b>			22d. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR. M.D.</b>			22e. ADDRESS <b>LONACONING MD 21539</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>6/23/1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Lonaconing, Md.</b>								
24. FUNERAL DIRECTOR <b>George Eichhorn</b>			ADDRESS <b>Lonaconing, Md.</b>			25a. REC'D BY REGISTRAR <b>JUN 23 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07716

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07707

1 DECEASED-NAME (Type or print)		First <b>Pora</b>	Middle <b>Mae</b>	Last <b>Bishop</b>	2a DATE OF DEATH Month Day Year <b>6/16/1969</b>		2b HOUR M
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>4/19/1885</b>		6 AGE (in years last birthday) <b>84</b> YRS.	
7a BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.	
10 CITY OR TOWN OF DEATH <b>Frostburg</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Miners Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased admission) STATE <b>MD.</b>		13b lived, if institution: Residence before <b>Allegany Lonaconing</b>		13c CITY OR TOWN <b>Allegany</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <b>James W Bishop</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Matilda Sperry</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>No</b>			
16b SOCIAL SECURITY NO <b>220-34-1920</b>		17 INFORMANT <b>Alban Bishop</b>		Address <b>Lonaconing, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Atherosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>years</b> <b>years</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Intestinal obstruction (gastrointestinal ileus)</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 15, 1969</b> , to <b>6-16, 1969</b> , that (I) (we) last saw the deceased alive on <b>June 15, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (do) (do not) view the body after death.							
22b. SIGNATURE <b>L. R. Miles</b>		DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>6.16.69</b>	
22d. PHYSICIAN'S NAME (Type) <b>L. R. MILES</b>		22e. ADDRESS <b>Lonaconing Md 21539</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/18/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Westernport, Md.</b>	
24. FUNERAL DIRECTOR <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>		25a. RECD BY REGISTRAR DATE <b>JUN 19 1969</b>		25b. REGISTRAR'S SIGNATURE <b>John A. Judge</b>	





07717

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07708

1 DECEASED NAME (Type or print) <i>Lera Virginia Borgman</i>			2a DATE OF DEATH June Month 10 Day 1969			2b HOUR 4:30 AM			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH June 2, 1890		6 AGE (In years last birthday) 79 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Allegany</i>			
10. CITY OR TOWN OF DEATH <i>Sonoma Md.</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kyle Nursing Home</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13d USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md.</i>		13c CITY OR TOWN <i>Allegany Cumberland</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>Bedford Road</i>			
14 FATHER'S NAME <i>John</i>		15 MOTHER'S MAIDEN NAME <i>Ellie Rowe</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO <i>None</i>		17 INFORMANT <i>Mrs. Irene McElfish</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4123 Myocardial Ischemia</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Artery Disease</i>		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Arteriosclerosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arteriosclerotic Semiplegia</i>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <i>June 9, 1969</i> , to <i>June 9, 1969</i> , that (I) (we) last saw the deceased alive on <i>June 9, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>L.R. Miles, Jr. M.D.</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>6-10-69</i>			
22d PHYSICIAN'S NAME (Type) <i>L.R. MILES, JR., M.D.</i>		22e ADDRESS <i>Sonoma, Md 21539</i>		23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <i>6/13/69</i>		23c NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cem.</i>	
23d LOCATION (City or town) <i>Cumberland, Md</i>		(County) <i>Allegany</i>		(State) <i>Md</i>		24 FUNERAL DIRECTOR <i>Louis Stein Inc</i>		25a REC'D BY REGISTRAR <i>Charles J. [Signature]</i>	
25b REGISTRAR'S SIGNATURE		25c DATE <i>JUN 12 1969</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07718

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07709

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI DEATH MATED		Month		Day		Year		2b HOUR	
Douglas		James		Carey				June		24		1969		8:30		M	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (n years last birthday)		7 UNDER YEAR		8 IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		Year	
Male	White	June 15, 1951		18 YRS.		MONTHS		DAYS		June 24		1969		19		8:30 M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH									
Maryland		U S A		WIDOWED		DIVORCED		Allegany								Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY											
Cumberland		Sacred Heart Hospital		Student													
13a USUAL RESIDENCE (Where deceased lived, admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS?		13e STREET AND NUMBER									
Maryland		Allegany		Frostburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Star Route									
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last			
James		Carey		Agnes		Wilhelm											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS									
No				215-58-6331		James Carey, Star Route, Frostburg, Md.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INTRACRANIAL HEMORRHAGE, CEREBRAL EDEMA 818.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BASILAR SKULL FRACTURE DUE TO, OR AS A CONSEQUENCE OF (c) MACERATION OF BRAIN																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 Hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOURLY about 7:30 PM 6-24-69				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Passenger--fell from moving vehicle									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) R+ #78				21f LOCATION Street or R.F.D. No. Edge of Frostburg, Allegany, Maryland				City or Town County State					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				Benedict Skitarelic, M.D. BENEDICT SKITARELIC, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b DATE SIGNED June 24, 1969 ADDRESS (Street, city, town, or county) Cumberland, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (State)					
Burial				June 28, 1969				Blocker Cemetery				Garrett (State) Allegany Md					
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE									
John J. Hafer, Jr.				John J. Hafer, Jr., 230 Balto Ave. Cumberland Md				JUN 27 1969				Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07719

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07710

1. DECEASED-NAME (Type or print)		First <b>VERNON</b>	Middle <b>ALBERTUS</b>	Last <b>CRABLE</b>	2a. DATE OF DEATH Month <b>6</b> Day <b>23</b> Year <b>69</b>		2b. HOUR <b>9:35AM</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>11-24-10</b>		6. AGE (In years last birthday) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>		Md	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Japanese Silk</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>CORRIGANVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Hilltop Drive</b>	
14. FATHER'S NAME First <b>HARRY</b> Middle <b>S.</b> Last <b>CRABLE</b>		15. MOTHER'S MAIDEN NAME First <b>ANNA</b> Middle <b>PRESTON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes, give war or date of service) <b>W. W. # 2</b>		16b. SOCIAL SECURITY NO. <b>217-10-7570</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterial hypertension, heart disease</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>4 y 1</b> <b>2 y 2</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arterial hypertension</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>5-27, 1967</b> to <b>6-23, 1969</b> , that (I) (we) last saw the deceased alive on <b>6-22, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Charles P. Dross</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6-24-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>DR. V. DROSS</b>				22e. ADDRESS <b>CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/26/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park,</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany Md.</b>			
24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JUN 27 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
07720								07711		
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
LOUIS			NMI			D'ALESSANDRO		Month 06 Day 25 Year 69 10:37A		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER YEAR		
MALE		WHITE		03-28-03		66 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
ITALY			USA				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			SACRED HEART HOSP.			RETIRED		NONE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ALLEGANY		CUMBERLAND		YES <input type="checkbox"/> NO <input type="checkbox"/>		726 OLDTOWN RD.,	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
DOMINIC			D'ALESSANDRO			LAURA BLACIOLI				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/> (If yes give year or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address					
NO			214-05-8846		HOSPITAL REC., 900 SETON DR., CUMB., MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIA, ACUTE &amp; CHRONIC, DUE TO</u>									4/17/69	
DUE TO, OR AS A CONSEQUENCE OF <u>ASPIRATION</u>										
DUE TO, OR AS A CONSEQUENCE OF <u>PARALYSIS OF SOFT PALATE &amp; VOCAL CORDS</u>									6 mos	
DUE TO, OR AS A CONSEQUENCE OF <u>Gen. muscular weakness due Neuromuscular disorder, etiology unknown</u>									?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Heart disease - atherosclerosis &amp; unknown muscular disorder duration 2y.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M.								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> , 19 <u>60</u> , to <u>6/25</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>6/25</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
<u>S. G. WEISSMAN</u>								6/26/69		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
S. G. WEISSMAN M.D.				59 GREENE ST., CUMBERLAND, MD. 21502						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		June 27, 1969		St. Peter & Paul Cem.		Cumberland, Allegany, Md.				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
SCARPELLI FUNERAL HOME, 108 VA. AVE., CUMB., MD.				JUN 30 1969		<u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07721 CERTIFICATE OF DEATH 07712									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
MABEL			A. DEATELHAUSER			Month 6 Day 20 Year 69		11:15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birth day)		7. UNDER 1 YEAR	
FEMALE		WHITE		11-12-9-11-12-91		77 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		MO.	
CUMBERLAND		USA				ALLEGANY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		HWF		HOME			
13a. U.S. JAL RES DENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21502 14 MASS. AVE., CUMB., MD.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
HENRY WRIGHT			INDIANA (SHOOK)			SHOOK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war and dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT				
NO			214-05-9376		SACRED HEART HOSPITAL PTS CHART 900 SETON DRIVE CUMB., MD. 21502				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>hypertensive pneumonia</u>									2 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arterio-sclerotic - vascular disease</u>									6 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2-31-1969, to 6-20-1969, that (I) (we) last saw the deceased alive on 6-20-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
L. BRINGS, M.D.								6-21-69	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
				57 GREENE ST., CUMB., MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 23, 1969		Davis Memorial Cemetery		Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SCARPELLI FUNERAL HOME 108 VA. AVE. CUMB., MD. 21502				JUN 24 1969		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07722

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07714

1 DECEASED-NAME (Type or print) <b>Priscilla Jane Evans</b>			2a. DATE OF DEATH Month <b>6</b> Day <b>21</b> Year <b>1969</b>			2b. HOUR <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov, 8th. 1921</b>		6. AGE (In years lost birthday) <b>47</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b> Md.	
10. CITY OR TOWN OF DEATH <b>Lonaconing</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Celanesse Employee</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Lonaconing</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>State Street</b>		14. FATHER'S NAME First Middle Last <b>Jacob Click</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Priscilla Powell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO		17. INFORMANT <b>Robert W. Evans, Cumberland, Md</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma Uterus</b> <b>1829</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb.</b> , 19 <b>69</b> , to <b>June 21, 1969</b> , that (I) (we) last saw the deceased alive on <b>June 20, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we did not) view the body after death.							
22b. SIGNATURE <b>L.R. Miles, Jr. M.D.</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6-22-69</b>	
22d. PHYSICIAN'S NAME (Type) <b>L.R. MILES, JR. M.D.</b>				22e. ADDRESS <b>LONA CONING, MD, 21539</b>			
23a. BURIAL, CREMATION, or MOVING (Specify) <b>Burial</b>		23b. DATE <b>6/24/1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Frostburg, Md.</b>	
24. FUNERAL DIRECTOR <b>George Eichhorn, Lonaconing, Md.</b>				25a. REC'D BY REGISTRAR <b>June 26 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07723 Item 23 Film 413 6/20/69 kk									
CERTIFICATE OF DEATH									
07715									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
James Stanley Foard						June 13 Day Year		1969 4: P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
Male		White		7-24-1896		72 YRS.		MONTHS DAYS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Allegany Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland			Memorial Hospital			Retired Carman		Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.			Allegany			Cumberland		1011 Virginia Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John R. Foard			Hannah E. Burkins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
Yes War I						Mrs. Berdie Foard, Cumberland, Md. Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4109 Acute Coronary Occlusion minutes APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular disease years									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June 13, 1968, to June 13, 1969, that (I) (we) last saw the deceased alive on June 13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
G. Overton Himmelmright, M.D.		7-15-69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
G. Overton Himmelmright, M.D.		133 Va. Ave, Cumberland, Md. 21502							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 16, 1969		Porter Cemetery		Cumberland Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Ma.		JUN 17 1969				Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Nellie Mae Fraley						Month Day Year 6 20 69		8:30 a. M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR		
Female		White		11/29/1902		66 YRS.		MONTHS DAYS HOURS M N		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md		U.S.A.				Allegheny Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			Memorial Hospital			House Work		Own Home		
13a. USLA. RES DENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md			Allegheny		Lonaconing		X		Beachwood Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Theodore Knepp			Martha Mathes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no					William Fraley		Lonaconing, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Myocardial infarction										
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from 6/1/1967 to 6/20/1969, that (I) (we) last saw the deceased alive on 6/20/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE						22c. DATE SIGNED				
PETER B HALMOS MD						6/24/69				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
PETER B HALMOS						207 SCHLEY ST. CUMBERLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6/23/69		Oak Hill Cemetery		Lonaconing, Md.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
George Eichhorn						DATE JUN 26 1969		Charles Judge		

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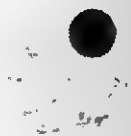
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
CORA M. FREELAND						JUNE 10, 1969		8:55PM	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 IF UNDER 1 YEAR	
FEMALE		WHITE		3-25-90		79 YRS.		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MARYLAND		U. S. A.				ALLEGANY			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL		HOUSEWIFE		OWN HOME			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER	
W. VA.		MINERAL		WILEY FORD				None	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
PETER TWIGG			SARAH ROBERTSON						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT Address			
						MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per age in (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ca of liver</u>									3 mo.
177.8 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No City or Town County State					
				Cynth Allegany Md					
22a. I certify that (I) (this hospital) attended the deceased from 4/17/69, 19, to 5/10/69, 19, that (I) (we) last saw the deceased alive on 5/10/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE				22c DATE SIGNED					
R.J.WMS.				4/11/69					
22d PHYSICIAN'S NAME (Type)				22e ADDRESS					
				122 S. CENTRE ST., CUMBERLAND, MD.					
23a BURIAL, CREMATION, or other disposition		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		June 13, 1969		Hillcrest Burial Park		Cumberland, Md. Allegany			
24 FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
James F. Scarpelli, Cumberland, Md.				JUN 16 1969		James Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH Month Day Year	
ADAM		E.		FROST				Month 06 - 18 Year 69	
3. SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7b UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE		WHITE		02 - 26 - 82		87 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
MARYLAND		U.S.A.				ALLEGANY COUNTY, Md			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		KOPPERS COMPANY		TOOL MAKER			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				6 E. ROBERT STREET	
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME First Middle Last	
AUGUST		FROST						AUGUSTA FROST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
NO		214 - 05 - 9317		SACRED HEART, SETON DR., CUMB., MD. 21502					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		LEFT VENTRICULAR FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		3 WEEKS	
4124		DUE TO, OR AS A CONSEQUENCE OF		ACVD		8 YEARS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
ARRERIAL EMBOLISM INTO RIGHT LEG (TERMINAL)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from 5 - 9, 19 56, to 6 - 18, 19 69, that (I) (we) lost saw the deceased alive on 8, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)		22e ADDRESS			
R.W. BALLIN		M 6 - 19 - 69		R.W. BALLIN, M.D.		62 GREENE STREET, CUMB., MD. 21502			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		June 20, 1969		Rose Hill Cemetery		Cumberland, Allegany, Md.			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
SCARPELLI FUNERAL HOME, VIRGINIA AVE., CUMB.		MD. 21502		JUN 24 1969		[Signature]			

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07727		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07719	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print)		First Middle Last <b>JOHN WILLIAM GORMER</b>		2a. DATE OF DEATH Month Day Year <b>JUNE 1- 1969</b>		2b. PMR <b>6:40</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>5-22-1907</b>		6 AGE (In years last birthday) <b>62</b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give address) <b>MEMORIAL HOSPITAL</b>		12a. SOCIAL OCCUPATION (Kind of work done if retired) <b>Machine Cleaner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>		13e. STREET AND NUMBER <b>101 WILLS CREEK AVE.,</b>	
14 FATHER'S NAME First Middle Last <b>GEORGE W. GORMER</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>SARAH E. HITE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO <b>214-05-4729</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetes Mellitus with Coma 6 hrs?</b> <b>1000</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Art. C.V. &amp; with possible infarction</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> not while at work		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/4/64</b> , 19 <b>64</b> , to <b>6/1/69</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>6/1/69</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>T. F. Lusby</b>		22c. DATE SIGNED <b>6/2/69</b>		22d. PHYSICIAN'S NAME (Type) <b>DR. T. F. LUSBY</b>			
22e. ADDRESS <b>932 NATIONAL HIGHWAY, LAVALE, MD.</b>							
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/4/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery,</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany Md.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George 202 Greene St. Cumb. Md.</b>				25a. REC'D BY REGISTRAR <b>JUN 6 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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07728

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07720

1. DECEASED-NAME (Type or print) James H. Gray			First	Middle	Last	2a. DATE OF DEATH Month Day Year June 13, 1969			2b. HOUR 5:12 PM		
3 SEX Male		4 RACE White		5. DATE OF BIRTH June 13, 1949		6 AGE (in years last birthday) 19 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Anne Arundel Md					
10. CITY OR TOWN OF DEATH Pikesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1554	
14. FATHER'S NAME First Middle Last Carl H. Gray			15. MOTHER'S MAIDEN NAME First Middle Last Dorothy E. Gray								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 217-10-1234			17 INFORMANT Mrs. Mildred Gray			Address 1554		
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cor. C.A.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute myocardial infarction approx. 1 hr.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u> <u>Few hours</u>		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 13, 1969</u> , to <u>June 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 13, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John A. Rogers MD</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>June 15, 1969</u>			
22d. PHYSICIAN'S NAME (Type) <u>John A. Rogers MD</u>						22e. ADDRESS <u>Memorial Hospital - Cumberland, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <u>June 13, 1969</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Memorial</u>			23d. LOCATION (City or Town) (County) (State) <u>Annapolis Anne Arundel Md.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>1554</u>						25a. REC'D BY REGISTRAR DATE <u>JUN 19 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Richard S. Sledge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07729

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07721

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
FRANK			G.	GREEN		6	Month	26	Day	69	Year
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
MALE			WHITE			6/9/88			81 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
W. VA.			USA						ALLEGANY Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			SACRED HEART HOSPITAL								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MD.			ALLEGANY			WESTERNPORT			RT 1 -BOX 81		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
WALTER GREEN			MAHALIA GREEN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
NO			212 03 5100			SACRED HEART HOSPITAL			-900 SETON DRIVE CUMBERLAND, MD. 21202		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
6-25-69			Upper GI Bleeding			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year								
			P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (I) (the hospital) attended the deceased from 6-23-69, to 6-26-69, that (I) (we) last saw the deceased alive on 6-26-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
DR. MATTHEW L KAUFMAN			6-27-69								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
DR. MATTHEW KAUFMAN			912 SETON DRIVE -CUMBERLAND, MARYLAND								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			6-29-69			PHILOSC CEMETERY			WESTERNPORT -ALLEGANY - MD.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
						JUN 30 1969			Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

4122

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR
STELLA		Y.		HARRIS		6 Month 9 Day 69 Year		4:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS
FEMALE		WHITE		1/20/93		76 YRS.		MONTHS		DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		USA				ALLEGANY				MD
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND		SACRED HEART HOSPITAL		HOUSEWIFE						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD.		ALLEGANY		CUMBERLAND				613 LYNN STREET		
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First
DANIEL		YOUNG						AGNES		MC MILLEN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (known)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
NO		217-10-445B		SACRED HEART HOSPITAL		-900 SETON DRIVE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u>										
4122 DUE TO, OR AS A CONSEQUENCE OF <u>HYPERTENSIVE &amp; ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u>										
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. <u>5 YEARS</u>										
DUE TO, OR AS A CONSEQUENCE OF <u>DISEASE</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
NONE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		
22a. I certify that (I) (this hospital) attended the deceased from <u>5 - 20, 1957</u> , to <u>6 - 9, 1969</u> , that (I) (we) last saw the deceased alive on <u>6 - 9, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
Rosa W. Brinn								22c. DATE SIGNED		
								6-9-69		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
DR. R. W. BALLIN		62 GREENE ST -CUMBERLAND, MD.		21502						
23a. BURIAL, CREMATION, REMAINS (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		6/12/69		Hillcrest Burial Park		Cumberland Allegany Maryland				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
SILCOX-MERRITT FUNERAL SERVICE		404 DECATUR ST.		JUN 16 1969		Charles Judge				
CUMBERLAND, MARYLAND										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07731

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07723

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH @ Month Day Year		2b HOUR A. M. P. M.	
John		Johnson			June 18, 1969		10:45 A.M.	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		FUNDING YEAR MONTHS DAYS HOURS M.N.	
Male	White		8/2/1887		81 YRS			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland	U. S. A.				Allegany County			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cumberland	Allegany County Infirmary		Retired: Coal Miner		Mining			
13a USUAL RESIDENCE (Where deceased admission) STATE	13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland	Allegany		Lonaconing				Detmold Street	
14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT	
John	Elizabeth McMillan				216-05-5760		P.O. Box 599, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Gen. Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stroke</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>yes</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from May 1, 1969, to June 18, 1969, that (I) (we) last saw the deceased alive on June 17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		22c DATE SIGNED		22d PHYSICIAN'S NAME (Type)				
George M. Simons		6/18/69		Memorial Hospital, Cumberland, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		6/21/69		Oak Hill Cemetery		Lonaconing A. Md		
24 FUNERAL DIRECTOR				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
George Eichhorn				Lonaconing, Md.		JUN 23 1969 Charles Judge		

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1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

07732		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07724	
1. DECEASED NAME (Type or print)		First JESSE	Middle C	Last JUDY	2a. DATE OF DEATH Month 8 Day 7 Year 69		2b. HOUR 9:35AM
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 10-31-15		6. AGE (in years lost birthday) 53 YRS	
7a. BIRTHPLACE (State or foreign country) W. VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH ALLEGANY	
10. CITY OR TOWN OF DEATH CUMBERLAND		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL		12a. USUA. OCCUPATION (Kind of work done during most of workable life, even if retired) UNEMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USJAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY ALLEGANY		13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 411 PIEDMONT AVENUE		14. FATHER'S NAME First MICHAEL Middle S Last JUDY		15. MOTHER'S MAIDEN NAME First VIRGINIA Middle OUPS Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO (If yes give year or dates of service)		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Probable Carcinoma, left lung 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastases (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from May 23, 1969, to June 7, 1969, that (I) (we) lost saw the deceased alive on June 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Calvin Y. Hadidian				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/8/69	
22d. PHYSICIAN'S NAME (Type) DR. CALVIN HADIDIAN				22e. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE June 9, 1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REG STRAR DATE JUN 11 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
07733										
CERTIFICATE OF DEATH										
07725										
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Mary Margaret Kabosky						June 15, 1969		P.M.		
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Female		White		1/1/1911		58 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Maryland		U. S. A.				Allegany County		Md		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Cumberland		Allegany County Infirmary		Office: Sells Co., Inc.						
13a. USJA. RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Allegany		Cumberland				16 Pennsylvania Ave.,		
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last	
Thomas M. Lillard						Hannah Hogan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT P. O. Box 599, Address: Cumberland, Md.				
No						Allegany County Infirmary records.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident										
DUE TO, OR AS A CONSEQUENCE OF (b) Yes Arteriosclerosis										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Dec. 5, 1968, to June 15, 1969, that (I) (we) lost saw the deceased alive on June 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE George M. Simmons				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/17/69		
22d. PHYSICIAN'S NAME (Type) George M. Simmons				22e. ADDRESS Memorial Hospital, Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		June 18, 1969		St. Mary's Cemetery		Cumberland, Allegany, Md.				
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				ADDRESS		25a. REC'D BY REG STRAR DATE JUN 24 1969		25b. REGISTRAR'S SIGNATURE		

20770

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07734

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07726

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
GEORGE,		F.		KEARCHNER	Month 06 Day 23 Year 69		12:02		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7. UNDER 1 YEAR		
MALE	WHITE		02-18-22		47 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				ALLEGANY COUNTY, Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if seasonal)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACRED HEART HOSPITAL		JANITOR KELLY SPRINGFIELD TIRE CO.					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND		YES <input type="checkbox"/> NO <input type="checkbox"/>		UPPER HOMEWOOD ADD., BOX 199	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
LORANZE		KEARCHNER		(CATACH) EFFIE KEARCHNER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
YES		220-03-7617		SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>unfortunate heart failure</u>								1 month	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction</u>								3 days	
Conditions, if any, which gave rise to immediate cause (a) storing the underlying cause lost (c) <u>chronic disease</u>								3 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2-22-1969, to 4-22-1969, that (I) (we) last saw the deceased alive on 4-22-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L. Brings</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6-23-69			
22d. PHYSICIAN'S NAME (Type) L. BRINGS, M.D.				22e. ADDRESS 57 GREENE ST., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/25/69		Wiltcrest Burial Pl.		Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James Stein Inc.		Cumber. Md.		DATE JUN 25 1969		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

07735

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07727

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month <u>06</u> Day <u>14</u> Year <u>69</u>		2b HOUR M	
JAMES		PATRICK		KENNEY JR.				
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH 04-24-12		6 AGE (In years last birthday) 57 YRS.		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign) MARYLAND		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH ALLEGANY		Md.
10 CITY OR TOWN OF DEATH CUMBERLAND		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital specify address) SACRED HEART HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PIPE FITTER		12b KIND OF BUSINESS OR INDUSTRY PPG IND.		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before ordinary state) MARYLAND		13b COUNTY ALLEGANY		13c CITY OR TOWN FROSTBURG		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 61 W. MAIN ST.,
14. FATHER'S NAME First Middle Last JAMES PATRICK KENNEY SR.		15 MOTHER'S MAIDEN NAME First Middle Last MARY E. COUNIHAN						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <u>YES</u> (If yes give war or dates of service,)		16b SOCIAL SECURITY NO 216-01-8833		17 INFORMANT HOSPITAL REC., 900 SETON DR., CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>SEPTISEMIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEPATIC COMA</u> stating the underlying cause (c) <u>CIRRHOSIS</u> last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u> <u>5 YRS</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>HEMOCHROMATOSIS</u>								
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>69</u> , to <u>6-14</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-14</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <u>L. Michael Glick MD</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <u>6-15-69</u>		
22d. PHYSICIAN'S NAME (Type) L. MICHAEL GLICK MD				22e ADDRESS 912 SETON DR., CUMBERLAND, MD. 21502				
23a BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <u>6/17/69</u>		23c NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY		23d LOCATION (City or Town) (County) (State) FROSTBURG, ALLEGANY, MD.		
24 FUNERAL DIRECTOR HAVER SOWERS, 60 W. MAIN ST., FROSTBURG, MD. 21502		25a REC'D BY REGISTRAR JUN 23 1969		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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1. The first part of the document is a list of the names of the members of the committee.

2. The second part of the document is a list of the names of the members of the committee.

3. The third part of the document is a list of the names of the members of the committee.

4. The fourth part of the document is a list of the names of the members of the committee.

5. The fifth part of the document is a list of the names of the members of the committee.

6. The sixth part of the document is a list of the names of the members of the committee.

7. The seventh part of the document is a list of the names of the members of the committee.

8. The eighth part of the document is a list of the names of the members of the committee.

9. The ninth part of the document is a list of the names of the members of the committee.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)  
30M REV. 1/68

07736

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07728

1. DECEASED-NAME (Type or print) <b>Herald</b>			First <b>Myers</b>			Middle <b>Lambert</b>			Lost			2a. DATE OF DEATH <b>June</b> Month <b>18</b> Day <b>1969</b>			2b. HOUR <b>M</b>								
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>Dec. 13, 1917</b>			6. AGE (in years last birthday) <b>51</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Allegany</b> Md.														
10. CITY OR TOWN OF DEATH <b>Cumberland</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>B.O.A. Memorial Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Division Manager</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Store</b>														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>W. Va.</b>			13b. COUNTY <b>Mineral</b>			13c. CITY OR TOWN <b>Wiley Ford</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>None</b>											
14. FATHER'S NAME <b>E.A. Lambert</b>			First <b>E.A.</b>			Middle <b>Lambert</b>			Lost			15. MOTHER'S MAIDEN NAME <b>Laura Murphy</b>			First <b>Laura</b>			Middle <b>Murphy</b>			Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			(If yes give war or dates of service) <b>War II</b>			16b. SOCIAL SECURITY NO			17. INFORMANT <b>Mrs. Lucy Lambert, Wiley Ford, W. Va. - Wife</b>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Cardiac Failure</b> <b>2507</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>A.S. ar Hypertensive Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischaemic mellitus, severe</b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>10 years</b> <b>17 years</b>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from <b>11 June, 1965</b> , to <b>10 October, 1968</b> , that (I) (we) last saw the deceased alive on <b>10 October, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <b>W. Alfred Van Ormer</b>			DEGREE <b>Dr. W. A. Van Ormer, M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>20 June 1969</b>								
22d. PHYSICIAN'S NAME (Type) <b>Dr. W. A. Van Ormer, M.D.</b>			22e. ADDRESS <b>122 S. Centre St., Cumberland, Md.</b>																				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>June 21, 1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>														
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>			ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>			25a. REC'D BY REGISTRAR <b>JUN 24 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Richard J. Judge</b>														

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07737

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07729

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
WALKER		R.	LILLER		6 Month 19 Day 69 Year		8:30 M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 YRS.
MALE		WHITE		12-24-95		73		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Mo.
W. VA.		USA				ALLEGANY		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND		SACRED HEART HOSPITAL		RETIRED FROM KELLY		SPRINGFIELD		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER
MD.		ALLEGANY		CUMBERLAND				
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle
OLLIE			LILLER		(TASKER) MARY			LILLER
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address
NO				217-10-6792		HOSPITAL RECORDS		900 SETON DR. CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>								3 days
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								
(b) _____								
DUE TO, OR AS A CONSEQUENCE OF								
(c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Asthmatic Bronchitis</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No City or Town County State				
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work								
22a I certify that (I) (this hospital) attended the deceased from <u>5/24</u> , 19 <u>69</u> , to <u>6-19</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>6/19</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED		
<u>W. Spiggle MD</u>								
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS						
WAYNE D. SPIGGLE, MD.		912 SETON DRIVE CUMB., MD. 21502						
23a B. RIAL, CREMATON, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		June 22, 1969		Sunset Mem. Park		Cumberland, Md.		
24. FUNERAL DIRECTOR		ADDRESS		REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
KIGHT FUNERAL HOME		505 DECATUR ST. CUMBERLAND, MD.		DATE JUN 23 1969		<u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

07738

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07730

1 DECEASED NAME (Type or Print)		First <b>WILLIAM</b>	Middle <b>JOSEPH</b>	Last <b>LIPPOLD</b>	2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> <b>JUNE</b> Day <b>2</b> Year <b>1969</b>		2b HOUR <b>930AM</b>
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>FEB 24 1894</b>		6 AGE YRS <b>75</b>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month <b>JUNE</b> Day <b>2</b> Year <b>1969</b>
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY</b>	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL-DOA</b>		12a USJA. OCCUPATION (Kind of work done during last 12 months) <b>RETIRED PIANO TUNER</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c CITY OR TOWN <b>CUMBERLAND</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First <b>JOHN</b> Middle <b>D.</b> Last <b>LIPPOLD</b>		15. MOTHER'S MAIDEN NAME First <b>MARGARET</b> Middle <b>#</b> Last <b>COSGROVE</b>		13e. STREET AND NUMBER <b>122 BEDFORD STREET</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <b>YES</b>		16b SOCIAL SECURITY NO (If year, month or dates of service) <b>213-12-9115</b>		17. INFORMANT <b>Wm J. Lippold, Jr</b>		ADDRESS <b>Box 902 Leesburg, Va</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <b>CORONARY SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day Year HOUR A M P M <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <b>CUMBERLAND, MD.</b>		22b DATE SIGNED <b>JUNE 2, 1969</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>6/4/69</b>		23c NAME OF CEMETERY OR CREMATORY <b>S.S. Peter &amp; Paul Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>	
24 FUNERAL DIRECTOR <b>SILCOX-MERRITT FUNERAL SERVICE</b>		404 DECATUR STREET <b>CUMBERLAND</b>		25a REC'D BY REGISTRAR <b>10 JUN 5 1969</b>		25b REGISTRAR'S SIGNATURE <i>William J. Lippold</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 4 Film 413 6/25/69 kk  
Item 5 Film 413 6/20/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

07731

1. DECEASED NAME <b>07739 FLORENCE D LYTTLE</b>		2a. DATE OF DEATH Month <b>6</b> Day <b>18</b> Year <b>69</b>		2b. HOUR <b>5:50 AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE Black</b>	5. DATE OF BIRTH <b>12-20-25 1924</b>		6. AGE (In years last birthday) <b>44</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>	13c. CITY OR TOWN <b>CUMBERLAND</b>	13d. INSIDE CITY, M.T.S? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First Middle Last <b>JOSEPH E. SIMMS</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MANILLA HAWKINS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Septic Shock</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Generalized peritonitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>perforated gastric ulcer</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pneumonia</b>				
19a. DATE OF OPERATION <b>6-13-69</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Perforated ulcer</b>	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>6-13, 1969</b> , to <b>6-16, 1969</b> , that (I) (we) last saw the deceased alive on <b>6/16</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.				
22b. SIGNATURE <b>Andrew Stasko</b>		DEGREE <b>MD.</b>	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>6/16/69</b>
22d. PHYSICIAN'S NAME (Type) <b>DR. C. BOINSFIELD</b>		22e. ADDRESS <b>CUMBERLAND, MD.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/18/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Alleg. Md.</b>	
24. FUNERAL DIRECTOR <b>John J. Hater, Jr.</b>		25a. REC'D BY REGISTRAR <b>MIN 19 1969</b>	25b. REG. STRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

404 W

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
07740					CERTIFICATE OF DEATH					07732				
1 DECEASED NAME (Type or print)			First NELLIE		Middle GRACE		Last MACK		2a. DATE OF DEATH Month 06 Day 03 Year 69			2b. HOUR 4:35 PM		
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH 5-16-77			6 AGE (In years at birthday) 92 YRS.		7 IF UNDER 1 YEAR MONTHS		8 IF UNDER 24 HRS HOURS		9 IF UNDER 1 MIN MIN	
7a BIRTHPLACE (State or foreign country) WEST VIRGINIA			7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH ALLEGANY COUNTY						
10 CITY OR TOWN OF DEATH CUMBERLAND			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution) SACRED HEART HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during working life, even if retired) NONE			12b. KIND OF BUSINESS OR INDUSTRY NONE					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND			13b. COUNTY ALLEGANY			13c. CITY OR TOWN CUMBERLAND		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 408 WALNUT STREET				
14. FATHER'S NAME First HENRY			Middle HIGGINS		Last HUDSON		5 MOTHER'S MAIDEN NAME First ELIZABETH			Middle HUDSON		Last HUDSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 217-54-6336			17 INFORMANT HOSPITAL REC., 900 SETON DR., CUMB., MD.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Angerative heart failure, c pulmonary</u> <u>404x</u> DUE TO, OR AS A CONSEQUENCE OF <u>edema and hepatomegaly</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive and arteriosclerotic</u> DUE TO, OR AS A CONSEQUENCE OF <u>cardiovascular - renal disease</u> last (c) <u>unknown</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Central arteriosclerosis</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>5-21-1969</u> , to <u>6-3-1969</u> , that (I) (we) last saw the deceased alive on <u>3 June 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>S. G. Weisman MD</u>			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>4 June 69</u>						
22d. PHYSICIAN'S NAME (Type) S.G. WEISMAN MD			22e. ADDRESS 59 GREENE ST., CUMBERLAND, MD. 21502											
23a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>6/6/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks Cem.</u>			23d. LOCATION (City or Town) <u>Cumberland</u>		(County) <u>Allegany</u>		(State) <u>MD</u>		
24. FUNERAL DIRECTOR <u>STEINS FUNERAL HOME, CUMBERLAND, MD. 21502</u>			25a. RECD BY REGISTRAR <u>JUN 9 1969</u>			25b. REGISTRAR'S SIGNATURE <u>William J. Jones</u>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07741

CERTIFICATE OF DEATH

07733

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR								
MARTIN				LOUIS	I.	6 Month 6 Day 69 Year			11:45M								
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
MALE			WHITE			9/8/07			61 YRS.			MONTHS			DAYS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
MARYLAND			USA						ALLEGANY Md								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of last year)			12b. KIND OF BUSINESS OR INDUSTRY								
CUMBERLAND			SACRED HEART HOSPITAL			RUBBER WORKER											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER					
MD.			ALLEGANY			MT. SAVAGE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			ROUTE 1 -BOX 57					
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last						
WILLIAM				MARTIN		ELIZABETH				WATKINS		WATKINSMARTIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, NO (unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address								
			215-10-1243			SACRED HEART HOSPITAL			-900 SETON DRIVE CUMBERLAND, MD.								
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))																	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Military tuberculosis</u> <u>11.4</u> <u>44 HRS.</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Portal vein thrombosis</u> <u>Arteriosclerotic CVD</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>5-18</u> , 19 <u>69</u> , to <u>6-6</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED								
									6-10-69								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS														
DR. M. ROTHSTEIN			-48 BROADWAY			FROSTBURG, MARYLAND 21532											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)								
BURIAL			6-9-69			ST. GEORGE'S CEMETERY			MT. SAVAGE, MD.								
24. FUNERAL DIRECTOR			ADDRESS			25a. FUNERAL HOME			25b. DATE								
DURST FUNERAL HOME			-57 FROST AVENUE			FROSTBURG, MARYLAND 21532			JUN 12 1969								

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07742

07734

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 113. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1 DECEASED NAME (Type or Print) <b>Terry Garland Mc Donald</b>			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> <b>June 12 1969</b>			2b. HOUR <b>3P</b>			
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>March 26, 1969</b>	6 AGE (in years last birthday) <b>3</b>	IF UNDER 1 YEAR MONTHS <b>3</b> DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <b>June</b> Day <b>12</b> Year <b>1969</b>			2d. HOUR <b>3P</b>			
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b>						
10. CITY OR TOWN OF DEATH <b>Cumberland</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>500 Greene St.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>None</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institut on admission) STATE <b>W.Va.</b>			13b. COUNTY <b>Mineral</b>		13c. CITY OR TOWN <b>Wiley Ford</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>None</b>			
14. FATHER'S NAME <b>Terry Garland</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Linda K. Swaner</b>			First Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO <b>none</b>			17. INFORMANT ADDRESS <b>Mr. Carl Turner, Wiley Ford, W. Va.</b>						
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF Congenital Heart Disease (b) <b>Congenital Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>			EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>June 12, 1969</b>			
ADDRESS (Street, city, town, or county) <b>Cumberland, Md.</b>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>6-14-1969</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Gardens</b>			23d. LOCATION (City or Town) (County) (State) <b>La Vale, Md. Allegany</b>			
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>						ADDRESS			25a. REC'D BY REGISTRAR <b>JUN 16 1969</b>		25b. REGISTRAR'S SIGNATURE <i>James F. Scarpelli</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4119

07743

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 507 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07735

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Joseph I. McGregor						6	Month	9	Day	11-35	
3 SEX	4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male	White		2/2/1912			57 YRS.		MONTHS	DAYS	HOURS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MD.		USA.				Allegany Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Frostburg			Miners Hospital			Trucker-Self-employed					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD.			Allegany		Lonaconing		YES		Jackson Street		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Robert McGregor						Catherine Fitzpatrick					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT					
No						Mrs. Buna McGregor, Lonaconing, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Ischemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Pulmonary Fibrosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>2 years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Chronic Pulmonary Fibrosis</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)			21f. LOCATION			Street or R.F.D. No City or Town County State		
22a. I certify that (I) (th's hospital) attended the deceased from <u>June 9, 1969</u> , to <u>June 9, 1969</u> , that (I) (we) last saw the deceased alive on <u>June 9, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE <u>L.R. Miles, Jr. MD</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <u>6.10.69</u>		
22d. PHYSICIAN'S NAME (Type) <u>L.R. MILES, JR.</u>						22e. ADDRESS <u>LONA CONING, MD. 21539</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			6/12/1969			St. Marys Cemetery			Lonaconing, Md.		
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
GEORGE EICHHORN						Lonaconing, Md.			DATE JUN 11 1969		
									25b. REGISTRAR'S SIGNATURE <u>William S. Judge</u>		



1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH	
WYANT		C.		MESSMAN		JUNE 17 1969		2b. HOUR 2:15AM	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		JUNE 4, 1904		65 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
MARYLAND		USA				ALLEGANY		JEWELRY STORE	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give type and address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		SACKED HEART HOSPITAL							
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND				803 SHRIVER AVENUE	
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME	
WYANT		C		MESSMAN		(SELL) MARY		MESSMAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
NO		214-05-4272		HOSPITAL RECORDS, 900 SETON DRIVE, CUMB., MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchopneumonia of the lungs with metastases to the brain</i>									4 months
DUE TO, OR AS A CONSEQUENCE OF									2 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No		City or Town	
								County	
								State	
22a I certify that (I) (this hospital) attended the deceased from 1960 to 6/17/69, that (I) (we) last saw the deceased alive on 6/15/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22e ADDRESS		22c. DATE SIGNED			
<i>S.G. Weisman</i>		S.G. WEISMAN, M.D.		59 GREENE ST., CUMBERLAND, MD. 21502		6/17/69			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		6/19/69		St. Peter & Paul Cem.		Cumberland		Allegany Md	
24. FUNERAL DIRECTOR		25a REC'D BY REG. STRAR		25b REGISTRAR'S SIGNATURE					
STEINS FUNERAL HOME		CUMBERLAND, MD.		JUN 20 1969		<i>W. C. Jones</i>			

(1. )

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07745

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07737

1 DECEASED NAME (Type or print) James William Miller			2a. DATE OF DEATH Month Day Year June 8 1969			2b. HOUR 7:25 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 3/27/1880		6. AGE (In years last birthday) 89 YRS.	
7a. BIRTHPLACE (State or foreign country) W.Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Allegany, Cumberland Md.	
10. CITY OR TOWN OF DEATH Cumberland		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sylvan Retreat		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.) Plumber		12b. KIND OF BUSINESS OR INDUSTRY Self	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res'dence before admission) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 523 Vailey Street		14. FATHER'S NAME First Middle Last Charles Miller		15. MOTHER'S MAIDEN NAME First Middle Last Mary Blackburn		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk	
16b. SOCIAL SECURITY NO. 220-16-6894		17 INFORMANT Phylliss Rossworm, 611 Shriver Ave Cumberland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> 4367 (b) <u>Generalized arteriosclerosis</u> (c) <u>hypertension</u> Cond trans, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from <u>4/9/68</u> , 19 <u>68</u> , to <u>6/8</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6/7</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE <u>George M. Simons</u>		22c. DATE SIGNED <u>6/10/69</u>		22d. PHYSICIAN'S NAME (Type) <u>George M. Simons</u>		22e. ADDRESS <u>Cumberland Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Type) <u>Burial</u>		23b. DATE <u>6/11/1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland Alleg Md</u>	
24. FUNERAL DIRECTOR <u>John H. Hager, Jr.</u>		24a. ADDRESS <u>230 Balto Ave. Cumberland Md</u>		25a. REG'D BY REGISTRAR <u>JUN 12 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2000

4123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07746		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07738	
CERTIFICATE OF DEATH					
1. DECEASED NAME (Type or print)			First	Middle	Last
William			A.		Miller
2. DATE OF DEATH		12:45 P. M.		2b. HOUR	
Month 6 Day 5 Year 69				P. M.	
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (In years last birthday)	7 UNDER 1 YEAR
Male	White	1/19/1884		85 YRS	MONTHS DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH		
Pennsylvania	U. S. A.	Allegany County			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if not recent)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland	Allegany County Infirmary	Brakenman for P. R.			
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d ADDRESS	13e STREET AND NUMBER	
Maryland	Allegany	Ellerslie	X NO <input type="checkbox"/>	Ellerslie, Maryland	
14 FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	
Samuel			Miller	Ida Miller	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b SOCIAL SECURITY NO	17 INFORMANT			
	716-10-5699	P. O. Box 599, Address Cumberland, Md. Allegany County Infirmary records.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)					acute renal insufficiency approx 4 days
DUE TO OR AS A CONSEQUENCE OF (b)					Ch. AZH.D. many years
DUE TO OR AS A CONSEQUENCE OF (c)					arterio-sclerosis many years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
Cerebral A.S. with mental deterioration					
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
	HOUR A.M. Month Day Year P.M. 19				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)	21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1, 1968, to June 5, 1969, that (I) (we) last saw the deceased alive on June 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE		DEGREE		22c DATE SIGNED	
John A. Topper M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		6-6-69	
22d PHYSICIAN'S NAME (Type)		22e ADDRESS			
John A. Topper M.D.		Memorial Hospital, Cumberland, Md.			
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)		
Burial	June 8, 1969	Cooks Mills Cemetery	Hyndman P.D., Bedford Pa		
24 FUNERAL DIRECTOR	ADDRESS		25a RECD BY REGISTRAR	25b REGISTRAR'S SIGNATURE	
Harvey N. Frazier	Hyndman, Pa		JUN 10 1969	Registrar Judge	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div> <div>Item 23 Fill in</div> <div>8/7/69 kk</div> <div>07747</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>07739</div> </div>											
1. DECEASED NAME (Type or Print)						2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR		
James Richard Moore						June 13 1969			1:15 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years as of birthday)	7. IF UNDER 1 YEAR	8. F UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR		
Male	White	Dec. 4, 1929	39 YRS	MONTHS	DAYS	June 13 1969			1:15 PM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Maryland		USA				Allegany					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			D.O.A. Memorial Hospital - Yarmaster						Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.				Allegany		La Vale		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 5, Winchester Road	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Russell F. Moore				Violet Beall							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
yes				Korean		Mrs. Patricia Moore, Rt. 5 Winchester Rd. Wife					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion										Sudden	
4104 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Coronary Sclerosis										-----	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Dr. Benedict Skitarelic, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED			
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		June 13, 1969			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)		Rt. 9, Cumberland			
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town, county) (State)							
June 16, 1969		Porter Cemetery		Near Ellersville, Md. Pa.							
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
James F. Scarpelli, Cumberland, Md.								DATE JUN 17 1969		Charles Judge	

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2509

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 4, and 5, and 6, and 7, and 8, and 9, and 10, and 11, and 12, and 13, and 14, and 15, and 16, and 17, and 18, and 19, and 20, and 21, and 22, and 23, and 24, and 25, and 26, and 27, and 28, and 29, and 30, and 31, and 32, and 33, and 34, and 35, and 36, and 37, and 38, and 39, and 40, and 41, and 42, and 43, and 44, and 45, and 46, and 47, and 48, and 49, and 50, and 51, and 52, and 53, and 54, and 55, and 56, and 57, and 58, and 59, and 60, and 61, and 62, and 63, and 64, and 65, and 66, and 67, and 68, and 69, and 70, and 71, and 72, and 73, and 74, and 75, and 76, and 77, and 78, and 79, and 80, and 81, and 82, and 83, and 84, and 85, and 86, and 87, and 88, and 89, and 90, and 91, and 92, and 93, and 94, and 95, and 96, and 97, and 98, and 99, and 100, and 101, and 102, and 103, and 104, and 105, and 106, and 107, and 108, and 109, and 110, and 111, and 112, and 113, and 114, and 115, and 116, and 117, and 118, and 119, and 120, 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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First Anita	Middle Margaret	Last Moreland	2a. DATE OF DEATH June Month 6 <sup>th</sup> Day 69 Year			2b. HOUR 635AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 11-25-1895		6. AGE (In years last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Mo. St. Louis		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Allegany Md.					
10. CITY OR TOWN OF DEATH Cumberland, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumberland Nursing Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife & Fmr. Prop.		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 318 Prince George St.		
14. FATHER'S NAME First Joseph			Middle Versen		Last Josephine		15. MOTHER'S MAIDEN NAME First Josephine			Middle Harleess	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			(If yes give war or dates of service)		16b. SOCIAL SECURITY NO 215-20-7266		17. INFORMANT Mr. Harry Moreland 318 Prince George St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic angina lent failure</u> 2509 DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S. as Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> Approximate interval between onset and death <u>1 1/2 years</u> <u>10 years</u> <u>Since 1946</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Overweight</u> <u>Chronic Cholelithiasis &amp; Cholecystitis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1946</u> , 19 <u>69</u> , to <u>6 June</u> , 19 <u>69</u> , that (I) <u>was</u> lost saw the deceased alive on <u>5 June</u> , 19 <u>69</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) (did not) view the body after death.											
22b. SIGNATURE <u>W. A. Van Ormer, M.D.</u>						DEGREE ATTENDING PHYS		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>6 June 69</u>	
22d. PHYSICIAN'S NAME (Type) <u>W. A. VanOrmer, M. D.</u>						22e. ADDRESS <u>122 So. Centre St. Cumberland, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL, ETC. <u>Cremation</u>		23b. DATE <u>6/7/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>			23d. LOCATION (City or Town) <u>Washington,</u>		(County) <u>D. C.</u>		(State)
24. FUNERAL DIRECTOR <u>H. Wayne George 202 Greene St. Cumberland, Md.</u>						ADDRESS		25a. REC'D BY REGISTRAR <u>JUN 9 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Richard J. ...</u>	

2015



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13  
30M REV 1-69

07749				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07741			
1. DECEASED-NAME (Type or print) <i>Clarence - Nick Klow</i>				2a. DATE OF DEATH Month <i>June</i> Day <i>4</i> Year <i>1969</i>				2b. HOUR <i>10:13</i> AM			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>June 14, 1887</i>		6. AGE (In years last birthday) <i>82</i> YRS.		7. UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		8. UNDER 24 HRS HOURS <i></i> MIN <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>Kennel</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Allegany</i> Md.					
10. CITY OR TOWN OF DEATH <i>Frostburg</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Tristate St. Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Truck Driver</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Allegany</i>		13c. CITY OR TOWN <i>Frostburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Tristate St.</i>			
14. FATHER'S NAME First <i>Edward</i> Middle <i>Nick Klow</i> Last <i>Saxon</i>		15. MOTHER'S MAIDEN NAME First <i>Saxon</i> Middle <i>Thompson</i> Last <i>Thompson</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212 2-2884</i>		17. INFORMANT <i>LOUISE ROGERS</i>		Address <i>Frostburg, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>										<i>1 day</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>HEUD arteriosclerosis</i>										<i>Year 1/2</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>emphysema</i>										<i>Years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No <i></i> City or Town <i></i> County <i></i> State <i></i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>6/2</i> , 19 <i>69</i> , to <i>6/4</i> , 19 <i>69</i> , that (I) <del>was</del> last saw the deceased alive on <i>6/4/69</i> , 19 <i>69</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.											
22b. SIGNATURE <i>John B. Davis</i>		DEGREE <i></i>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6/4/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>John B. Davis, M.D.</i>		22e. ADDRESS <i>2 Broadway, Frostburg, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6/4/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>21st St. Cem.</i>		23d. LOCATION (City or Town) <i>Frostburg</i>		(County) <i>Allegany</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>Wm. J. Vannich</i>		ADDRESS <i>1111</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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FOR STATE  
HEALTH DEPT.

07750

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07742

1 DECEASED NAME (Type or Print)		First <b>R.</b>		Middle <b>ANIAN</b>		Last <b>PRICE</b>		2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year <b>June 6, 69</b>		2b HOUR <b>10a</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>FEB. 11, 1897</b>		6 AGE (In years last birthday) <b>72</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year <b>June 6, 1969</b> 19 <b>10a</b> M	
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ALLEGANY</b>					
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Sacred Heart Hospital-DOA</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RETIRED RAILROADER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>WM R. R.</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>				13b COUNTY <b>ALLEGANY</b>		13c CITY OR TOWN <b>ECKHART</b>		3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
14 FATHER'S NAME First Middle Last <b>OWEN PRICE</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>SARAH CLOSE</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16b SOCIAL SECURITY NO <b>WW 1</b>		17. INFORMANT ADDRESS <b>WILLIAM R. PRICE, LA VALE, MD. 21502</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS, GENERALIZED</b> DUE TO, OR AS A CONSEQUENCE OF 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CARCINOMA OF STOMACH, PRIMARY</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVA. BETWEEN ONSET AND DEATH <b>1 Year</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION <b>June 18, 1969</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Carcinoma of Stomach</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>June 6, 1969</b>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) <b>ALLEGANY</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 9, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Eckhart, Md.</b>					
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, FROSTBURG, MD. 21532</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 12 1969</b>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

0011



VR A15  
45M -

A15

MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> <span>07751</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>07743</span> </div>																							
1 DECEASED NAME (Type or print)			First <b>JAMES</b>			Middle <b>R.</b>			Last <b>PUFFENBARGER</b>			2a DATE OF DEATH Month <b>06</b> Day <b>24</b> Year <b>69</b>			2b HOUR <b>1:30</b> M								
3 SEX <b>MALE</b>			4 RACE <b>WHITE</b>			5. DATE OF BIRTH <b>10-03-90</b>			6 AGE (In years last birthday) <b>78</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>			IF UNDER 24 HRS HOURS <b></b> MIN <b></b>								
7a BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>ALLEGANY COUNTY</b> Md.														
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>			12a USUAL OCCUPATION (Kind of work done during last 12 months, even if retired) <b>CARPENTER</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Construction</b>														
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>W. VA.</b>			13b COUNTY <b>Mineral</b>			13c CITY OR TOWN <b>WILEY FORD</b>			13d INSIDE CITY, Y.N. 157 <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			13e STREET AND NUMBER <b>WILEY FORD, W. VA. 26767</b>											
14. FATHER'S NAME First <b>ANDY</b>			Middle <b></b>			Last <b>PUFFENBARGER</b>			15. MOTHER'S MAIDEN NAME First <b>ELIZABETH</b>			Middle <b>EYE</b>			Last <b>PUFFENBARGER</b>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>			16b SOCIAL SECURITY NO <b>705-10-8401</b>			17 INFORMANT Address <b>SACRED HEART, SETON DR., CUMB., MD. 21502</b>																	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Pulmonary Decompression</u>															12 hr								
492x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Emphysema</u>															unk.								
(c) <u>Pneumothorax</u>															unk.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic Heart Disease &amp; Atrial Fibrillation</u>																							
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b> P.M. <b></b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)																	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No <b></b> City or Town <b></b> County <b></b> State <b></b>																	
22a I certify that (I) (this hospital) attended the deceased from <u>6/17, 1969</u> , to <u>6/24, 1969</u> that (I) (we) lost the deceased on <u>6/23, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death																							
22b SIGNATURE <u>[Signature]</u>															DEGREE <b></b>			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <u>6/24/69</u>		
22d PHYSICIAN'S NAME (Type) <b>J.A. PAGAN, M.D.</b>															22e ADDRESS <b>1068 NATIONAL HWY., LA VALE, MD. 21502</b>								
23a BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>			23b DATE <b>June 26, 1969</b>			23c NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>			23d LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>														
24 FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <b>MD. 21502</b>															25a REC'D BY REGISTRAR <b>JUN 27 1969</b>			25b REGISTRAR'S SIGNATURE <u>[Signature]</u>					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

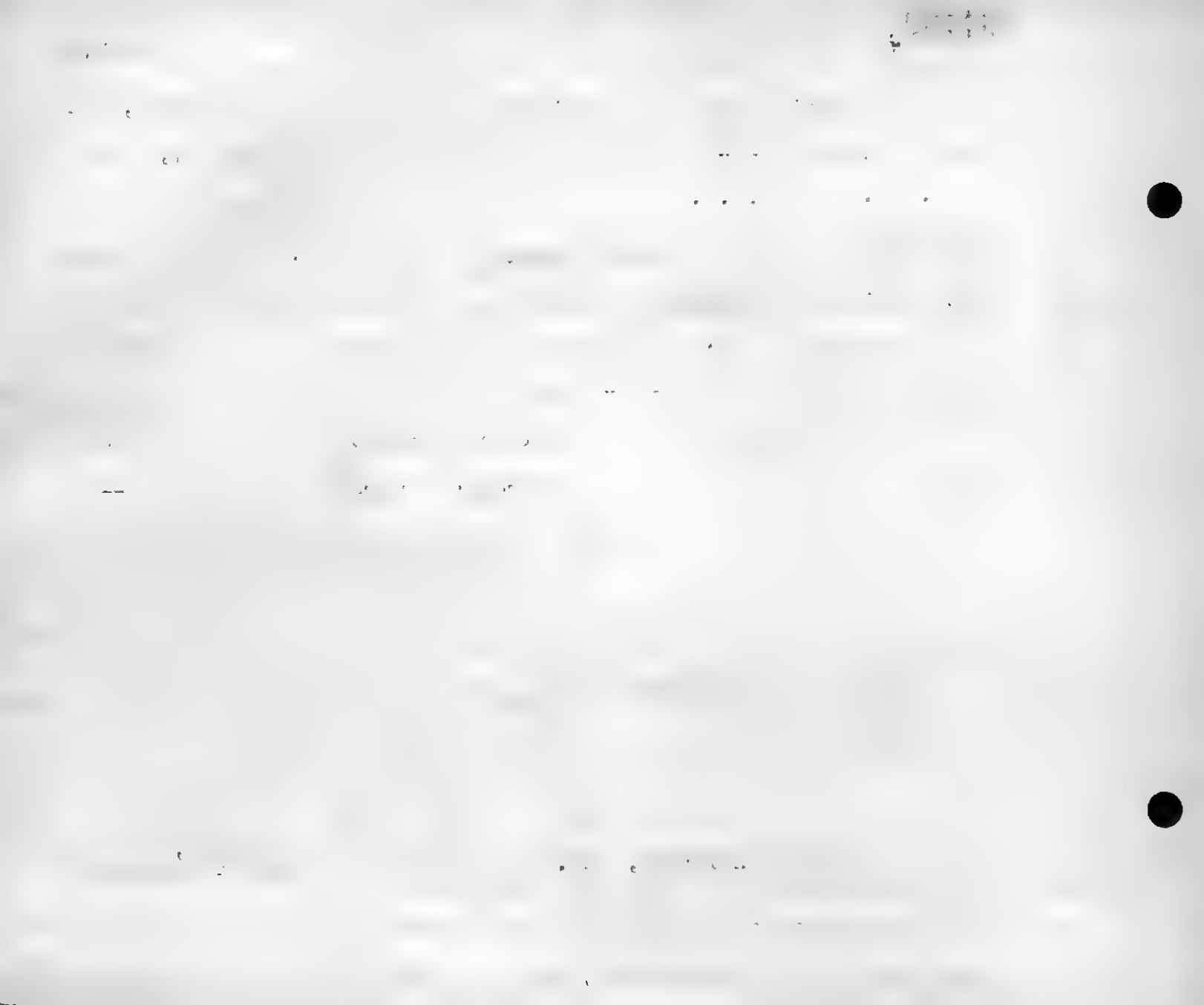
07752

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #6, Film 4414 7/7 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07744

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		XX Month		Day		Year		2b HOUR	
Florin Rudolph Raines								June 27, 1969								5:30p	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		2d HOUR	
Male	White	7-7-1900		69 YRS		MONTHS		DAYS		June 27, 1969						5:30p	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9. COUNTY OF DEATH									
W. Va.		U.S.A.		WIDOWED		DIVORCED		Allegany									
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
Cumberland		Memorial Hospital		self Emp. trucker		Hauling											
13a USUAL RESIDENCE (Where deceased permanently lived, if institution - Residence before)		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
West Virginia		Hampshire		Romney		YES		Box 81									
14. FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last			
Albert V. Raines								Chloe Smith									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		217-10-6715		Flora H. Raines		Springfield, W. Va.											
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c))		PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Coronary Occlusion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		1 Hour									
4109		DUE TO, OR AS A CONSEQUENCE OF		Coronary Sclerosis		---											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES		NO									
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
		19															
21d INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State							
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED		June 27, 1969							
EXAMINER'S NAME (Type)		Benedict Skitarelic, M.D.				DEPUTY MEDICAL EXAMINER		ADDRESS (Street, city, town, or county)		Cumberland, Maryland							
23a BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)							
Burial		6-30-69		Indian Mound Cemetery		Romney, Hampshire		W. Va.									
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE											
William G. Kight		Cumberland, Md.		JUL 2 1969		K. H. Jones											



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-6. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07758

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07745

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
FREDERICK ANON RANKIN						Month Day Year			3:30 PM		
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR
MALE	WHITE	NOV. 23, 1907	61 YRS	MONTHS	DAYS	HOURS	MIN.	Month Day Year			3:30 PM
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
MARYLAND			U.S.A.						ALLEGANY		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
FROSTBURG			Miners Hospital--DOA			LABORER			BRICKYARD		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY L.M. 57		
MARYLAND			ALLEGANY			BORDEN MINES			R.F.D. 2, BOX 305,		
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
ALEX RANKIN			CATHERINE McCREADY								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT					
NO			N.A.			BOX 305, FROSTBURG, MD.					
			214-01-0081			MRS. FREDERICK A. RANKIN, R.F.D. 2,					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Barbiturate Poisoning									1-2 Hours		
9500 DUE TO, OR AS A CONSEQUENCE OF (Self Administered)									"		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE: <i>Benedict Skitarelic</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 18, 1969			
				ADDRESS (Street, city, town, or county) ALLEGANY							
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
BURIAL			6/21/69			FROSTBURG MEMORIAL PARK			FROSTBURG, ALLEGANY, MD.		
24a. FUNERAL DIRECTOR			24b. ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
M. SOWERS			HOME, 60 W. MAIN, FROSTBURG			JUN 30 1969			<i>Charles Judge</i>		

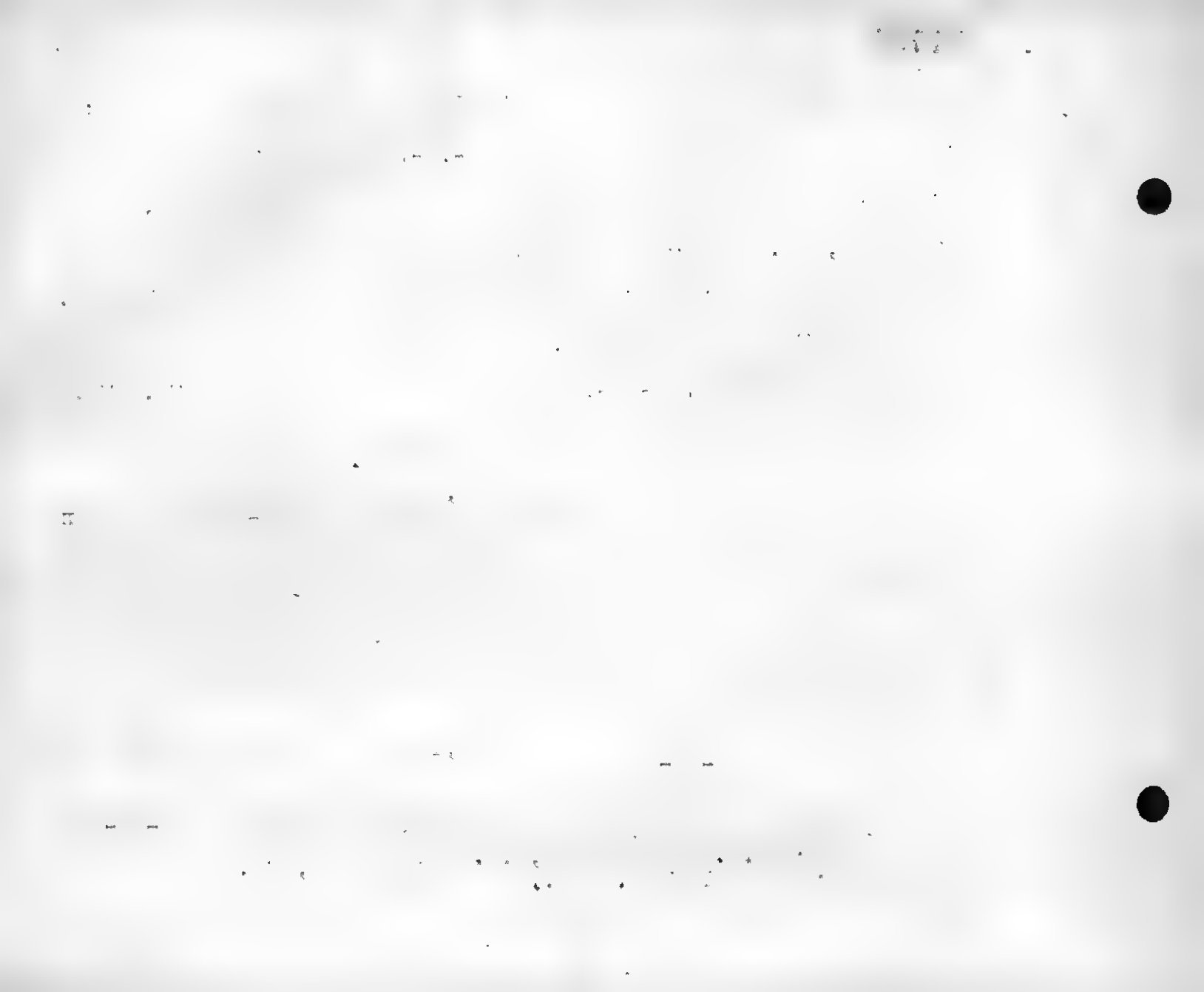
1944



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH	
LABON		C.		REXRODE		06		Month 22 Day 69 Year 3:50A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
MALE		WHITE		9-13-1885		83 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		UNITED STATES				ALLEGANY CO. Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND, MD.		MEMORIAL HOSPITAL		Real Estate Broker					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		CUMBERLAND		<input checked="" type="checkbox"/> NO <input type="checkbox"/>		474 BALTIMORE AVE.	
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME	
WILLIAM		REXRODE		ELIZA		JORDON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
NO		159-14-1581		MEMORIAL HOSPITAL		CUMB., MD.			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Refractory Heart Failure									
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.									
(b) Chronic and Acute Cor Pulmonale									
(c) Chronic Bronchitis, Pulmonary Emphysema and Pulmonary Fibrosis-Advanced (years)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Generalized Arteriosclerosis with Cerebral Insufficiency									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from May 19, 1969, to June 22, 1969, that (I) (we) last saw the deceased alive on 6-22-69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
								6-23-69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
XORIXXAMES 133 Va. Ave.,		CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/25/69		Pleasant Grove Cemetery		Cumberland Allegany Maryland			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Silcox-Merritt Funeral Service, Cumberland, Md		21502		JUN 25 1969					



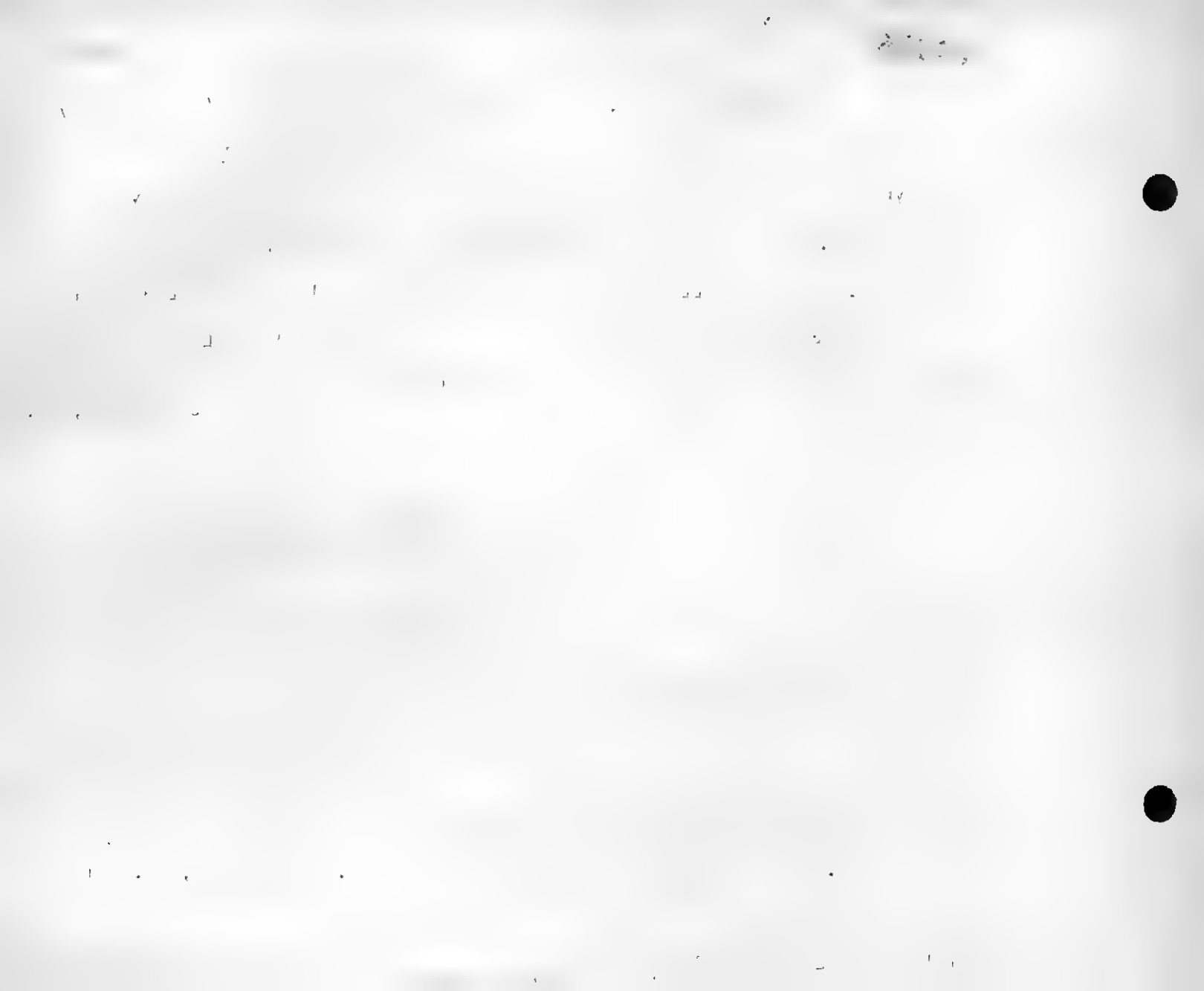


1890

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
ANNA M. RICKER						6 Month 4 Day 69 Year			7:50 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. JUNIOR 1 YEAR		
FEMALE		WHITE		7/6/95		73 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		USA				ALLEGANY Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work life or if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
CUMBERLAND			SACRED HEART HOSPITAL			HOUSEWIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MD.			ALLEGANY		LA VALE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1049 NATIONAL HIGHWAY	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
TERRANCE			WOODS			CATHERINE GILLESPIE WOODS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO					SACRED HEART HOSPITAL		900 SETON DRIVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>pneumonia</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) <u>hypertension</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work										
22a. I certify that (I) (this hospital) attended the deceased from <u>2-1</u> , 19 <u>64</u> to <u>6-4</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE				22c. DATE SIGNED		
<u>L. Brings MD</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				<u>6-5-69</u>		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
DR. LEWIS BRINGS				57 GREENE ST., CUMBERLAND, MD. 21502						
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>Burial</u>		<u>6/7/69</u>		<u>Sunset Memo Pk.</u>		<u>Cumberland Allegany MD</u>				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR								
<u>Louis Staudner</u>		DATE <u>JUN 9 1969</u>								
STEIN'S FUNERAL HOME - 117 FREDERICK STREET		25b. REGISTRAR'S SIGNATURE								
CUMBERLAND, MARYLAND 21502		<u>Walter</u>								



07756

## CERTIFICATE OF DEATH

07748

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
WILLIAM			H.		ROBERTSON	JUNE Month 19 Day 1969			1:12A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE		WHITE		10-4-93		75 YRS		MONTHS	DAYS	HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		USA				ALLEGANY Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
CUMBERLAND			MEMORIAL HOSPITAL							
13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MD.			ALLEGANY LONACONING							
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle Last
JOSEPH					ROBERTSON	ETHEL			L.	VAUGH
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT				
			164-10-3091			MEMORIAL HOSP., CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Terminal Cardiac failure</u> <u>4124</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S. Cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic lung disease, bronchitis, fibron emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u> <u>5 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Pneumonia, L. hemidiaphragm. known since 1963</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
15 Jan 69		Hypertension, acute left heart failure			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>14 Jan</u> , 19 <u>69</u> , to <u>19 Jan</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>18 Jan</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>W. Alfred Van Ormer M.D.</u>					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>19 Jan 69</u>	
22d. PHYSICIAN'S NAME (Type) <u>DR. VAN ORMER</u>					22e. ADDRESS <u>CUMBERLAND, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		6/21/1969		Laurel Hill Cemetery			Moscow, Md.			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
EICHORN FUNERAL HOME, LONACONING, MD.							JUN 23 1969		<u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**07757**

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**07749**

1. DECEASED-NAME (Type or Print) <b>LESTER ELWOOD SINES</b>			2a. DATE KNOWN OF EST- DEATH MATED <input checked="" type="checkbox"/> <b>June 13, 1969</b>			2b. HOUR <b>6:45 P.M.</b>		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>April 7, 1905</b>	6 AGE (In years last birthday) <b>64 YRS</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>June</b> Day <b>13</b> , Year <b>1969</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Allegany</b>		
10. CITY OR TOWN OF DEATH <b>Cumberland,</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>D. O. A. Sacred Heart</b>			12a. LSUA. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Custodian</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Laboratory</b>
3a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Maryland</b>			3b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cresaptown,</b>	3d. INSIDE CITY LIM TST YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Craddock Road</b>	
14. FATHER'S NAME First <b>Henry</b> Middle <b>B.</b> Last <b>Sines</b>			15. MOTHER'S MAIDEN NAME First <b>Harriet</b> Middle <b>--</b> Last <b>Mankis</b>					
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-10-2804</b>		17. INFORMANT <b>Mrs. Iva Mae Sines, Cresaptown, Md. 21502</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO, OR AS A CONSEQUENCE OF <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>---</b> DUE TO, OR AS A CONSEQUENCE OF <b>---</b> (c) <b>---</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 HRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			June 13, 1969		
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M. D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Rt. # 9		
			ADDRESS (Street, city, town, or county)			Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>6/16/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany Md.</b>		
24. FUNERAL DIRECTOR <b>H. Wayne George, Cumberland, Md. 21502</b>				25a. REC'D BY REGISTRAR <b>JUN 17 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

3. 3. 3

180X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151  
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
07758					07750				
1 DECEASED NAME (Type or print) First Middle Last <b>HELEN A. SKIDMORE</b>					2a DATE OF DEATH 6 Month 13 Day 69 Year			2b HOUR 4:30 PM	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>12-19-24</b>		6 AGE (In years last birthday) <b>44</b> YRS		7 UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY</b> Md			
10 CITY OR TOWN OF DEATH <b>CUMBERLAND,</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>SACRED HEART HOSPITAL</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b COUNTY <b>ALLEGANY</b>		13c CITY OR TOWN <b>FROSTBURG</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>25 FROST VILLAGE</b>	
14 FATHER'S NAME First Middle Last <b>JOHN JONES</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>(MOORE) CARRIE JONES</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give year or dates of service) <b>NO</b>		16b SOCIAL SECURITY NO <b>214-24-0982</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>900 SETON DR. CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Uterine Cervix</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>FEB</u> , 19 <u>69</u> , to <u>6-13</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-13</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>L. M. Glick</u> MD DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <u>6-13-69</u>		
22d PHYSICIAN'S NAME (Type) <u>L. M. Glick</u>					22e ADDRESS <u>BRADDOCK MED GROUP-CUMBERLAND MD</u>				
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE <u>6/16/1969</u>		23c NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Moscow, Md.</u>			
24 FUNERAL DIRECTOR <u>EICHORN FUNERAL SERVICE</u>					ADDRESS <u>8 E. MAIN LONACONING, MD.</u>		25a. RECD BY REGISTRAR <u>JUN 17 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07759		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		07751	
Item 5 Film 6/23/69 kk		CERTIFICATE OF DEATH			
1. DECEASED NAME (Type or print) <b>WILLIAM</b> <sup>First</sup> <b>R. E.</b> <sup>Middle</sup> <b>SMITH</b> <sup>Last</sup>		2a. DATE OF DEATH <b>JUNE</b> <sup>Month</sup> <b>13</b> <sup>Day</sup> , <b>1969</b> <sup>Year</sup>		2b. HOUR <b>7:05 AM</b>	
3 SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>7-12-97</b> <sup>1897</sup>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) <b>MEMORIAL HOSPITAL</b>		9. COUNTY OF DEATH <b>ALLEGANY</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ALLEGANY</b>		13c. CITY OR TOWN <b>CUMBERLAND</b>	
13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>1100 BEDFORD ST.,</b>			
14. FATHER'S NAME <sup>First</sup> <b>WILLIAM</b> <sup>Middle</sup> <b>H.</b> <sup>Last</sup> <b>SMITH</b>		15. MOTHER'S MAIDEN NAME <sup>First</sup> <b>KATHERINE</b> <sup>Middle</sup> <b>KING</b> <sup>Last</sup>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>		16b. SOCIAL SECURITY NO <b>214-05-5162</b>		17 INFORMANT <b>MEMORIAL HOSPITAL, CUMB. MD.</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Terminal cardiac failure, sudden</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Bronchial Pneumonia, R.L.L.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>A.S. Cardiovascular disease with frequent decompensation 1951</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic pancreatitis and chronic cholecystitis with cholelithiasis.</b>					
19a. DATE OF OPERATION <b>6/13/69</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Exploratory laparotomy with cholecystectomy</b>		20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR <b>19</b> A.M. Month <b>6</b> Day <b>13</b> Year <b>1969</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>19 51</b> , to <b>15 June</b> , <b>19 69</b> , that (I) (we) last saw the deceased alive on <b>15 June</b> , <b>19 69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W. Alfred Van Ormer, M.D.</b>		22c. DATE SIGNED <b>16 June 1969</b>		22d. PHYSICIAN'S NAME (Type) <b>DR. W. A. VANORMER</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/17/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	
23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>		24. FUNERAL DIRECTOR <b>Silcox-Merritt Funeral Service, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REG. STRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>JUN 17 1969</b>		25d. REG. STRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07760

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07752

1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> OF DEATH ESTI- MATED <input type="checkbox"/>			Month Day Year			2b. HOUR					
Daniel			E.			Snider			June 30			1969 10A M					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD					
Male		White		May 29, 1901		68 YRS						Month June Day 30 Year 1969 10A M					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH								
Maryland			USA						Allegany Md								
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cumberland				D.O.A. Memorial H.										Retired Machinist		Railroad	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER							
W.Va.				Mineral		Ridgeley				11 Jones Steet							
14. FATHER'S NAME First Middle Last						15. MOTHER'S MAIDEN NAME First Middle Last											
Alonzo Snider						Hattie Smallwood											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS											
yes				War II		Mrs. Mabel Corwell, Ridgeley, W.Va.-Sister											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion												Sudden					
4109 DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis												-----					
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
				19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No		City or Town		County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED					
Benedict Skitarelic				Dr. Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				June 30, 1969					
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) Rt. 9, Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				July 3, 1969		Mt. Herman Cemetery				Cumberland, Allegany, Md.							
24. FUNERAL DIRECTOR ADDRESS								25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE							
James F. Scarpelli, Cumberland, Md.								JUL 7 1969		Charles Judge							

1955



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07761

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07753

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month		Day		Year		2b HOUR			
John		Roy		Snyder				June 3		19		69		7		p m			
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		Year			
Male	White	Aug. 18, 1905		63		MONTHS		DAYS		June 3		19		69		8 p m			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9. COUNTY OF DEATH											
Md.		U.S.A.		WIDOWED		DIVORCED		Allegany											
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY							
Barton				Rt. 1				Clerk				Gro. Store							
13a USUA. RESIDENCE (Where deceased lived, if institution Residence before adrn ssion) STATE				13b COUNTY				13c CITY OR TOWN				3d INSIDE CITY LIMITS?				13e STREET AND NUMBER			
Md				Allegany				Barton				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				Rt. 1			
14 FATHER'S NAME				15 MOTHER'S MAIDEN NAME															
John				Snyder				Flavia				Snyder							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17 INFORMANT				ADDRESS							
no				217-01-1525				Helene Snyder-Arlinton, Va.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION, LEFT DUE TO, OR AS A CONSEQUENCE OF CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF CORONARY SCLEROSIS PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No				City or Town							
												County							
												State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				Benedict Skitarelic				M.D.				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				Benedict Skitarelic, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
								ADDRESS (Street, city, town, or county)				Allegany							
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town)				(County) (State)			
Burial				6/6/69				Lanier Hill				Moscow Mills - Md.							
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE							
E. J. Boal - Westernport, Md								JUN 5 1969				E. J. Boal							



4100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07762

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07754

1 DECEASED NAME (Type or print) First Middle Last <b>*MAUDE* MAUDIE E. SOLBERG</b>		2a DATE OF DEATH Month <b>06</b> Day <b>16</b> Year <b>69</b>		2b HOUR <b>1:00</b> M
3 SEX <b>FEMALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>6-1-98</b>	6 AGE (In years last birthday) <b>71</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>W. VA.</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>ALEEGANY</b> Md.	
10. CITY OR TOWN OF DEATH <b>MARYLANDCUMBERLAND,</b>	11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>SACRED HEART HOSPITAL</b>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>NONE</b>	12b KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
13a USUA. RESIDENCE (Where deceased lived, if institution address) <b>MARYLAND</b>	13b COUNTY <b>ALLEGANY</b>	13c CITY OR TOWN <b>CUMBERLAND</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <b>RT 4,</b>
14 FATHER'S NAME First Middle Last <b>JOHN F. BARGER</b>	15. MOTHER'S MAIDEN NAME First Middle Last <b>SARAH COSNER</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)	16b SOCIA. SECURITY NO <b>NONE</b>	17 INFORMANT Address <b>HOSP. REC. 900 SETON DR., CUMB. MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>POSTERIOR MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>HYPERTENSION</b>				
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <b>69</b>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC	21f LOCATION Street or R.F.D. No City or Town County State		
22a I certify that <b>(H)</b> (this hospital) attended the deceased from <b>NOV 1968</b> , to <b>16 JUNE 1969</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>16 JUNE 1969</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(I)</b> (we) (did) (did not) view the body after death.				
22b SIGNATURE <b>Dr. Glick</b>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c DATE SIGNED <b>6-16-69</b>	
22d PHYSICIAN'S NAME (Type) <b>DR. GLICK</b>		22e ADDRESS <b>912 SETON DR., CUMB. MD.</b>		
23a BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>	23b DATE <b>6/19/1969</b>	23c NAME OF CEMETERY OR CREMATORY <b>Glendale Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Allegheny County Md.</b>	
24 FUNERAL DIRECTOR <b>HAFFER, 230 BALTI. AVE., CUMBERLAND, MD.</b>	25a REC'D BY REG STRAR <b>JUN 18 1969</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07763										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07755									
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										4. SEX									
LILLIAN MAE STEELE										Month 6 Day 29 Year 69										FEMALE									
3. SEX										4. RACE										5. DATE OF BIRTH									
FEMALE										WHITE										12-19-1904									
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED									
BEDFORD, PA.										U. S. A.										X NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INST. T.T. ON (If not a hospital give street address)										9. COUNTY OF DEATH									
CUMBERLAND										MEMORIAL HOSPITAL										ALLEGANY									
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE										13b. COUNTY										13c. CITY OR TOWN									
MD.										ALLEGANY										BA VALE									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?									
WILLIAM LAYTON										MARY										No									
16b. SOCIAL SECURITY NO.										17. INFORMANT										18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))									
None										MEMORIAL HOSPITAL-CUMBERLAND, MD.										PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE - Cerebrovascular</u>									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?									
																				YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. INJURY OCCURRED										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)									
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from <u>26 June 1969</u> to <u>29 June 1969</u> , that (I) (we) last saw the deceased alive on <u>29 June 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE										22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS										22f. SIGNATURE									
DR. FULLER B. WHITWORTH										305 WASHINGTON ST., CUMBERLAND,										29 June 69									
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY									
Burial										7/2/69										Hillcrest Burial Park									
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
H. Wayne George Cumberland, M.d.										JUL 3 1969										Richard Judge									



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15141  
45M 41/69

1977



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07765		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07757	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print)		First <b>LAWRENCE</b>		Middle <b>EARL</b>		Last <b>SUMMERS</b>	
2a. DATE OF DEATH		Month <b>06</b>		Day <b>22</b>		Year <b>69</b>	
2b. HOUR		10:15					
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>07-04-12</b>		6 AGE (in years last birthday) <b>56 YRS.</b>	
7a BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY COUNTY,</b>	
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SACRED HEART HOSPITAL</b>		12a USUAL OCCUPATION (Kind of work done during year of working life, even if retired) <b>SUPPLY MAN - WESTERN MD. RAILROAD</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>W. VA.</b>		13b COUNTY <b>MINERAL</b>		13c CITY OR TOWN <b>RIDGELEY</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>3 SECOND AVENUE</b>		14 FATHER'S NAME First <b>JAMES</b>		Middle <b>W.</b>		Last <b>SUMMERS</b>	
15 MOTHER'S MAIDEN NAME First <b>(REED)</b>		Middle <b>SARAH</b>		Last <b>K. SUMMERS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT Address <b>MD. 21502</b>			
				<b>SACRED HEART HOSPITAL, 900 SETON DR., CUMB.,</b>			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Liver failure + uraemia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Bleeding + Portal Embolism</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intestinal bleeding - fistula due to Cholecystitis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND OFATH <u>2 months</u> <u>10 yrs</u> <u>10 yrs</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <b>5/9/69</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Intestinal bleeding fistula</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , to <u>6/22, 1969</u> , that (I) (we) lost saw the deceased alive on <u>6/22, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>S.G. Weisman</u>		DEGREE <b>S.G. WEISMAN, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6/23/69</b>	
22d. PHYSICIAN'S NAME (Type) <b>S.G. WEISMAN, M.D.</b>		22e. ADDRESS <b>59 GREENE ST., CUMB., MD. 21502</b>					
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>		23b. DATE <b>6/25/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park,</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany Md.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b>		ADDRESS <b>GEORGE FUNERAL HOME-202 GREENE ST., CUMB., MD.</b>		25a. RECEIVED BY REGISTRAR <b>JUN 26 1969</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07766

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07758

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED		Month	Day	Year	2b HOUR
LINDA		M.		SWAUGER	June 21, 1969		June	21	1969	7:30 AM
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	2c DATE PRONOUNCED DEAD		Month	Day
FEMALE	WHITE	JULY 21, 1952		16 YRS			June 21, 1969		Year	19 7
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
MARYLAND		U.S.A.				ALLEGANY				
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY				
CUMBERLAND		SACRED HEART HOSPITAL--DOA		HOUSE WIFE		HOME				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INS DE CITY LIMITS?		13e STREET AND NUMBER		
MARYLAND		ALLEGANY		FROSTBURG		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		158 E. COLLEGE AVENUE		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last	
GEORGE				BARRY	DOLORES				BOLINGER	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		
				218-60-1751		MRS. DOLORES BARRY, FROSTBURG, MD. 21532				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock										10-15 Min.
819.1 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
(b) Retroperitoneal Hemorrhage										11
DUE TO, OR AS A CONSEQUENCE OF										
(c) Fractured Pelvis										11
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
								YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)						
		6:45 PM June 21 1969		Passenger in auto accident						
21d INJURY OCCURRED		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Rt. #40		0.4 miles west of Frostburg,		Allegany,		Maryland		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		BENEDICT SKITARELIC, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED		
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		June 21, 1969		
EXAMINER'S NAME (Type)		BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
						CUMBERLAND, MARYLAND				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)
BURIAL		JUNE 25, 1969		SUNSET MEMORIAL PARK		CUMBERLAND, MD.				
24 FUNERAL DIRECTOR				ADDRESS				25a REG'D BY REG STRAR		25b REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532								JUN 26 1969		





13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07767

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07759

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Virginia Caroline Thuss						June 17 1969			4:00 M		
3. SEX	4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female	White		May 1, 1910			59 YRS.		MONTHS	DAYS	HOURS	
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland			USA					Allegany Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			511 Williams St.			Housewife & Beautician			Own Home		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Allegany			Cumberland		YES		511 Williams St.	
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	
William N. House						Henrietta Roberts					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address		
no						Mr. Ralph J. Thuss, Husband			Cumberland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>INTRACEREBRAL NEOPLASM</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>(GLIOBLASTOMA MULTIFORME)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mon	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>May 3, 1969</u> to <u>May 17, 1969</u> , that (I) (we) lost saw the deceased alive on <u>May 15, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
Wayne C. Spiggle		6-18-69			W. C. STIGGLE		CUMBERLAND Md				
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)		
Buried		June 20, 1969		Hillcrest Burial Park		Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
James F. Scarpelli, Cumberland, Md.					DATE JUN 20 1969		John C. Judge				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 18. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div style="display: flex; justify-content: space-between;"> <span>07768</span> <span>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</span> <span>07768</span> </div>										
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR	
JAMES			Everett			Trail			<input checked="" type="checkbox"/> Month Day Year <input type="checkbox"/> ESTIMATED <b>June 28, 1969</b>	12:01
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS DAYS	8 IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD			2d HOUR	
Male	White	5/23/35	34 YRS.			<input checked="" type="checkbox"/> Month <b>June 28, 1969</b> or <b>12:01</b>			M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Penna.		USA				Allegany County Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Cumberland			Memorial Hospital--DOA			Laborer - Tire & rubber co.				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER			
Pa.			Bedford			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	RD 1, Flintstone, Md.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Ralph M. Trail			Lelia C. O'Neal							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
No			200-28-3644		Mrs. Leona Trail, RD1, Flintstone, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									Minutes	
5110 Cardiac Tamponade										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										
(b) Compression Rupture Pulmonary Vein									Sudden	
DUE TO, OR AS A CONSEQUENCE OF										
(c) (Fractured Sternum)									11	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
About 11:30PM 6-27-69					Driver of Auto involved in accident.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
			Rt. #40: 1.3 miles east from top Martins Mt., Allegany, Maryland							
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED				
<i>Benedict Skitarelic</i>			M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)			Benedict Skitarelic, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 28, 1969</b>				
						ADDRESS (Street, city, town, county, state)				
						Cumberland, Maryland 21530				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		6/30/69		Mt. Zion Christian Cem.		Southampton Twp., Bed. Co. Penna.				
24 FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE				
Conner Funeral Service, Everett, Pa.				JUL 2 1969		<i>Charles Ind...</i>				

80537

FOR STATE  
HEALTH DEPT.

07769

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07761

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN <input checked="" type="checkbox"/> OF ESTI DEATH MATED <input type="checkbox"/> Month Day Year			2b HOUR		
George Edward Twigg						June 17, 1969			9:30 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year			2d HOUR
Male	White	July 25, 1948	20 YRS					June 17, 1969			9:40 P.M.
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			USA						Allegany Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			MEMORIAL HOSPITAL--DOA			Laborer			Construction		
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY, IN 15'		
Md.			Allegany			Cumberland			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		
John W. Twigg			Ora Belle Wertz			no					
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Donald E. Twigg, Valley Rd. Cumberland, Md.			Brother			PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMOTHORAX, LEFT DUE TO, OR AS A CONSEQUENCE OF RUPTURE OF AORTA (b) DUE TO, OR AS A CONSEQUENCE OF (c)			MINUTES MINUTES		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
			(9:12 P.M. June 17 19 69)			Motorcycle rider head-on crash with car.					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
			Street			Fairview & Pulaski Sts. Cumberland, Allegany, Maryland					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASS. STANT MEDICAL EXAMINER			22b DATE SIGNED		
BENEDICT SKITARELIC, M.D.									JUNE 17, 1969		
EXAMINER'S NAME (Type)			ADDRESS			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town)		
			CUMBERLAND, MARYLAND								
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			June 21, 1969			Zion Memorial Park			Cumberland, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
James F. Scarpelli, Cumberland, Md.						JUN 20 1969					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Department prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07770										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										07762																																																	
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																																	
First <b>LAVENIA</b>										Middle <b>M.</b>										Last <b>WADE</b>										6 Month 1 Day 69 Year										12:25 PM																													
3 SEX <b>FEMALE</b>										4 RACE <b>WHITE</b>										5. DATE OF BIRTH <b>2-6-86</b>										6 AGE (in years last birthday) <b>83</b> YRS.										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN																			
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>										7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH <b>ALLEGANY</b>										Md.																													
10 CITY OR TOWN OF DEATH <b>CUMBERLAND</b>										11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <b>SACRED HEART HOSPITAL</b>										12a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>										13b. COUNTY <b>ALLEGANY</b>										13c. CITY OR TOWN <b>FROSTBURG</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER <b>255 E. MAIN ST.,</b>									
14. FATHER'S NAME First <b>RANDOLPH</b>										Middle <b>DENNISON</b>										Last <b>DENNISON</b>										15 MOTHER'S MAIDEN NAME First <b>(RASE)</b>										Middle <b>ANNIE</b>										Last <b>DENNISON</b>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year and dates of service) <b>N.A.</b>										16b. SOCIAL SECURITY NO <b>348-12-8584</b>										17 INFORMANT <b>HOSPITAL RECORDS</b>										Address <b>900 SETON DR. CUMBERLAND, MD.</b>																																							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3440</b> DUE TO, OR AS A CONSEQUENCE OF <b>MITRAL STENOSIS &amp; INSUFFICIENCY</b> (b) DUE TO, OR AS A CONSEQUENCE OF <b>RHEUMATIC HEART DISEASE</b> (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																																	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or RFD No City or Town County State																																																	
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>68</u> , to <u>6-1</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6-1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																					
22b. SIGNATURE <i>L. M. Glick</i> MD										DEGREE <b>MD</b>										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <b>6-1-69</b>																																							
22d. PHYSICIAN'S NAME (Type) <b>L. M. GLICK, MD</b>										22e. ADDRESS <b>912 SETON DR., CUMBERLAND, MD.</b>																																																											
23a. BURIAL, CREMATION OR REMOVAL (Specify)										23b. DATE <b>JUNE 4, 1969</b>										23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>										23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, ALLEGANY, MD.</b>																																							
24. FUNERAL DIRECTOR <b>HAFFER-SOWER FUNERAL HOME</b>										ADDRESS <b>FROSTBURG, MD.</b>										25a. REC'D BY REGISTRAR <b>JUN 5 1969</b>										25b. REGISTRAR'S SIGNATURE <i>Thomas Judge</i>																																							





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

077771

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07763

1 DECEASED-NAME (Type or Print) <b>ALVIN JOSLIN WALTERS</b>			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>June 19, 1969</b>			2b HOUR <b>5:45p M</b>
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5 DATE OF BIRTH <b>JUNE 27, 1921</b>	6 AGE (In years last birthday) <b>47</b> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month Day Year <b>June 19, 1969</b>
7a BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>ALLEGANY</b>
10 CITY OR TOWN OF DEATH <b>FROSTBURG</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DEPOT ROAD</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>		13b COUNTY <b>ALLEGANY</b>		13c CITY OR TOWN <b>FROSTBURG</b>		13d INSIDE CITY - M 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e STREET AND NUMBER <b>DEPOT ROAD</b>		14 FATHER'S NAME First Middle Last <b>ALVIN JOSLIN WALTERS</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>MARGARET ROBERTS</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No, if unknown) <b>YES</b>		16b SOCIAL SECURITY NO <b>W.W. II 479-12-2203</b>		17 INFORMANT <b>FROSTBURG, MD. MRS. ALVIN J. WALTERS, DEPOT ROAD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot of Abdomen and Chest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>(Self inflicted)</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		22b. DATE SIGNED <b>June 19, 1969</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6/22/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, ALLEGANY, MD.</b>
24. FUNERAL DIRECTOR <b>MARYLOU M. SOWERS, HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG</b>				25a. REC'D BY REGISTRAR <b>JUN 30 1969</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4379

07772

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07764

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
JAMES		ARTHUR	WEISENBORNE	JUNE		Month 15	Day 1969	Year	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE	WHITE		AUG. 26, 1885		83 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md		
MARYLAND	U.S.A.				ALLEGANY				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR IND. STRY			
CUMBERLAND		SACRED HEART HOSPITAL		ELECTRICIAN & FOREMAN		COAL COMPANY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		ALLEGANY		ECKHART					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
First Middle Last				First Middle Last					
HENRY WEISENBORNE				CATHERINE		KREITZBURG			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
NO		213-09-6551A		MRS. LOLA WEISENBORNE, ECKHART, MD.		21528			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute brain syndrome									
4379 DUE TO, OR AS A CONSEQUENCE OF (b) Circulatory disturbance									
Conditions, if any, which gave rise to immediate cause (a), starting the underlying cause last (c) Cerebral arteriosclerosis								9 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Chronic bilateral obstructive pulmonary disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from May 28, 1969, to June 15, 1969, that (I) (we) last saw the deceased alive on June 15, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
A. PAIGE STRONG, M.D.								June 16, 1969	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
		167 E. MAIN ST., FROSTBURG, MD.		21532					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		JUNE 18, 1969		ECKHART CEMETERY		ECKHART, MD.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REGD. BY REGISTRAR			
JOSEPH R. DURST, FROSTBURG, MD. 21532						25b. REGISTRAR'S SIGNATURE			



4109

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div> <div>07773</div> <div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> </div> <div>07765</div> </div>											
1 DECEASED-NAME (Type or print) <div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div> <div>GEORGE</div> <div>F</div> <div>WINFIELD</div> </div>					2a. DATE OF DEATH <div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div> <div>JUNE</div> <div>2</div> <div>1969</div> </div>					2b. TIME <div> <div>PM</div> <div>11:35</div> </div>	
3. SEX <div>MALE</div>		4. RACE <div>WHITE</div>		5. DATE OF BIRTH <div>6-28-09</div>		6. AGE (In years last birthday) <div>59</div>		IF UNDER 1 YEAR <div>MONTHS</div> <div>DAYS</div> <div>HOURS</div> <div>MIN</div>		IF UNDER 24 HRS <div>MIN</div>	
7a. BIRTHPLACE (State or foreign country) <div>CUMB. MD.</div>		7b. CITIZEN OF WHAT COUNTRY? <div>USA</div>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <div>ALLEGANY</div>					
10. CITY OR TOWN OF DEATH <div>CUMBERLAND</div>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <div>MEMORIAL HOSPITAL</div>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <div>B &amp; O R. R.</div>			12b. KIND OF BUSINESS OR INDUSTRY 		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <div>MD.</div>			13b. COUNTY <div>ALLEGANY</div>		13c. CITY OR TOWN <div>CUMBERLAND</div>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <div>Knob Rd., Box 21</div>		
14. FATHER'S NAME <div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div> <div>WILLIAM</div> <div>J</div> <div>WINFIELD</div> </div>				15. MOTHER'S MAIDEN NAME <div> <div>First</div> <div>Middle</div> <div>Last</div> </div> <div> <div>MARY</div> <div>A</div> <div>HIMMER</div> </div>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <div>705-09-3430</div>		17. INFORMANT <div>MEMORIAL HOSPITAL, CUMBERLAND, MD.</div>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div>3</div>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY <div> <div>HOUR</div> <div>A.M.</div> <div>Month</div> <div>Day</div> <div>Year</div> </div> <div> <div>P.M.</div> <div>19</div> </div>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-30-1967</u> , to <u>6-2-1967</u> , that (I) (we) last saw the deceased alive on <u>6-2-1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <div>DR. W. DROSS</div>										22c. DATE SIGNED <div>6-5-1969</div>	
22d. PHYSICIAN'S NAME (Type) <div>DR. W. DROSS</div>					22e. ADDRESS <div>456 N. CENTRE ST., CUMBERLAND, MD.</div>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <div>Burial</div>		23b. DATE <div>6/5/69</div>		23c. NAME OF CEMETERY OR CREMATORY <div>Sunset Memorial Park</div>			23d. LOCATION (City or Town) (County) (State) <div>Cumberland Allegany Maryland</div>				
24. FUNERAL DIRECTOR <div>Silcox-Merritt Funeral Service, Cumberland, Md</div>					ADDRESS <div>21502</div>		25a. REC'D BY REGISTRAR <div>JUN 5 1969</div>		25b. REGISTRAR'S SIGNATURE <div>Richard S. Judge</div>		



3093

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07774

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07766

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR M		
Betty Ruth Younkin						June 22, 1969					
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
F	W		July 16, 1941			27 YRS.					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Pa.		U. S. A.				Allegany Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Frostburg			Minors Hosp.			NONE					
13a USUAL RESIDENCE (Where deceased admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
Md.				Garrett Grantsville				R. D. 1			
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MA DEN NAME			First	Middle	Last
Clayton					Younkin	Ruth					Swauger
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.			17 INFORMANT			Address		
No						Clayton Younkin			Grantsville, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute brain syndrome</u>											
4589 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) <u>Circulatory disturbance</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Vascular lesion, nature undetermined</u>										1 day	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Chronic, severe convulsive disorder</u>											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION		Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>June 21, 1969</u> , to <u>June 22, 1969</u> , that (I) (we) lost saw the deceased alive on <u>June 22, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>A. Paige Strong</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 6/23/69				
22d PHYSICIAN'S NAME (Type) A. Paige Strong					22e ADDRESS Frostburg, Md.						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial		6/25/69		Grantsville Cem.			Grantsville, Garrett, Md.				
24 FUNERAL DIRECTOR <u>Louie Human, Grantsville, Md</u>					25a. REC'D BY REGISTRAR DATE JUN 25 1969		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

VR A15  
45M





MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07775

07767

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
George L. Zimerla						Month Day Year			a		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE		
Male			White			Dec. 12 1904			64 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U.S.A.						Allegany Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cumberland			MEMORIAL HOSPITAL-DOA			Retired Mechanist			Kelly Tire Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Allegany			Cumberland			116 Independent Street.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		
William			Zimerla			Ursula (Unknown)					
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Mrs. George L. Zimerla			Cumberland Md.			PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION			SUDDEN		
4109			DUE TO, OR AS A CONSEQUENCE OF			CORONARY THROMBOSIS, LEFT			"		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF			CORONARY SCLEROSIS		
(c)									-----		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			Pulmonary emphysema								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			XX JUNE 17, 1969		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			6/19, /69			Trinity Luth. Cem.			Cumberland /Allegany/ Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Steins Funeral Home, Cumberland, Maryland						JUN 20 1969			<i>Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07768

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR		
RUTH		A.		ZOLLNER	JUNE 7 1969		4:35 M		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		
FEMALE	WHITE		11-12-1886		82 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD.		USA				ALLEGANY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
CUMBERLAND		MEMORIAL HOSPITAL							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD.		ALLEGANY		CUMBERLAND				BOX 2141 STATION A	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
BENJAMIN				BARNHART	LORETTA				SCHLESSER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
no				MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Lung from</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cause of Left Breast</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>ye</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1967</i> , to <i>June 7, 1969</i> , that (I) (we) lost <i>and</i> that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>B. Schindler</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6/8/69</i>			
22d. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER				22e. ADDRESS 43 GREENE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 10, 1969		Mt. Oliver Cemetery		Near Hancock, Md.			
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE JUN 11 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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11-12-1966	WHITE	11-12-1966	WHITE
ALLIED	ALLIED	ALLIED	ALLIED
GENERAL HOSPITAL	GENERAL HOSPITAL	GENERAL HOSPITAL	GENERAL HOSPITAL
NO. 1	NO. 1	NO. 1	NO. 1
BATHING	BATHING	BATHING	BATHING
GENERAL HOSPITAL	GENERAL HOSPITAL	GENERAL HOSPITAL	GENERAL HOSPITAL

James I. Thompson, Charleston, S.C.  
 Burial June 10, 1969 St. Oliver Cemetery  
 New London, Md.  
 11-12-1966, 11-12-1966, 11-12-1966, 11-12-1966